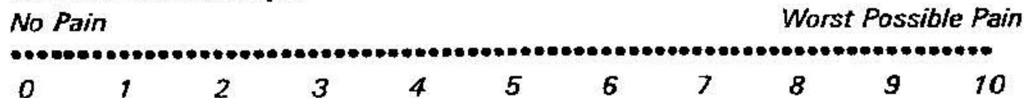
L.A. Orthopaedic Center
Tae Shin, M.D.

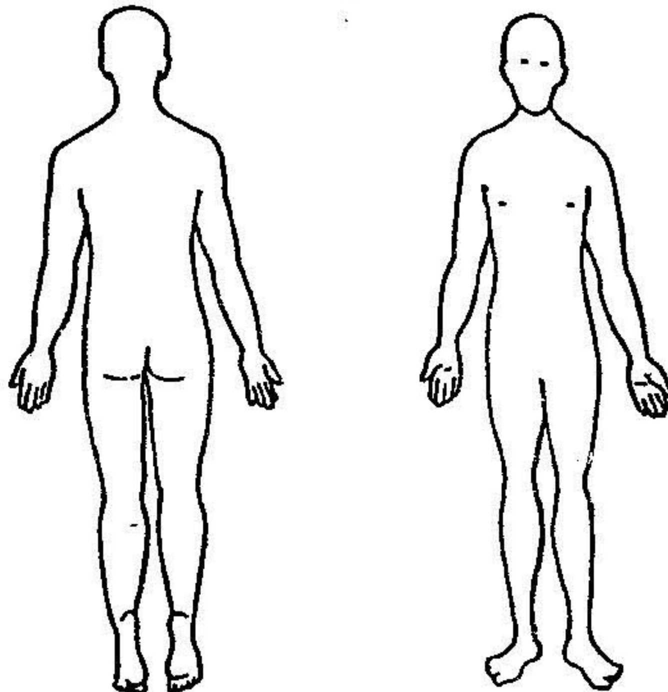
Please mark on this line an X at the point that corresponds to your average <u>BACK/NECK</u> pain over the last few days.

Please mark on this line an X at the point that corresponds to your average <u>LEG/ARM</u> pain over the last few days.



Using the symbols below mark the areas on your body where you fell the described sensations.

ΔΔΔ Numbness XXX Burning pain + + + Other pain
OOO Pins and needles /// Stabbing pain □□□ Aching pain



Please check the activities that make you feel better or worse?

	Better	No change	Worse
Lying on back			
Standing			
Sitting			
Walking			
Bending forward to brush teeth			
Exercising			

PATIENT NAME: ______________________________

Are you experiencing any:

	No	Yes	If yes, explain
Bladder problems			
Bowel problems			
Fevers			
Chills			
Recent weight changes			
Change in appetite			

When did the symptoms begin? ___/___/___

What was the cause of the symptoms?
Work injury___, Motor vehicle accident___, Fall___, Sports___, Other___

Have you had similar symptoms before? No___, Yes___ If yes, when? ___/___/___

Have you had any diagnostic tests? (please list date and place where the test was performed if known)

___X-Ray ___/___/___ ______________________________
___Bone Scan ___/___/___ ______________________________
___MRI ___/___/___ ______________________________
___CT Scan ___/___/___ ______________________________
___Myelogram ___/___/___ ______________________________
___EMG ___/___/___ ______________________________
___Discogram ___/___/___ ______________________________

Have you had any of the following treatments for your symptoms? (please list date when performed)

___Bed rest ___/___/___ ______________________________
___Back brace ___/___/___ ______________________________
___Physical therapy ___/___/___ how long?______________________________
___Chiropractor ___/___/___ ______________________________
___Acupuncture ___/___/___ ______________________________
___Epidural injections ___/___/___ ______________________________
___Facet injections ___/___/___ ______________________________
___Other injections ___/___/___ ______________________________
___Pain clinic ___/___/___ ______________________________

What is your current work status?

___Unable to work because of the pain
___Working part time or light duty because of pain
___Working full time and full duty
___Unemployed
___Retired
___Student

If you're out of work, how long? ______________________________

Because of your pain, are you currently receiving:

	No	Yes	Applying for
Workers' Compensation			
Social Security Disability			
Private Disability			

Are you involved in a personal injury lawsuit because of your pain? No___, Yes___

Do you have any medical problems? (please list)______________________________

____

____

____

List all medications you are taking including dosage and frequency ________________

____

____

____

Have you had any prior surgeries? (please list with dates) ______________________

____

____

____

Are you allergic to any medications? ____

Do you use tobacco? No___, Yes___ **How much?** ____________________________

Do you drink alcohol? No___, Yes___ **How often?** ___________________________

Have you had any of the following problems in the recent 3 months? (please check)

___Headaches

___Seizures, Head injuries

___Loss of concentration, memory problems

___Visual or hearing impairment, glaucoma

___Asthma or respiratory problems

___Chest pain, heart disease, arrhythmias

___Hypertension

___Family history of heart disease

___Elevated cholestrol

___Abdominal pains

___Ulcers, hiatus hernia

___Hepatitis or liver disease

___Diabetes

___Arthritis____________________

___Shortness of breath

___Cough

___Osteoporosis

___Kidney, urine or bladder problems

___Menstrual difficulty or possibility of pregnancy

___Pelvic pain

___Cancer_____________________________

___Family history of cancer________________

___Infections____________________________

___Bleeding tendencies

___Blood clots, phlebitis

___Anemia or blood disorders

___Thyroid or other hormonal problems

___Depression

___Anxiety

___Stress

___Fainting

___Swollen feet/ankles

Please mark only one box that most closely describes your problem.

Question 1 – Personal Care (washing, dressing, etc)

0 ( ) I can look after myself normally without causing extra pain
1 ( ) I can look after myself normally, but it causes extra pain
2 ( ) It is painful to look after myself, and I am slow and careful
3 ( ) I need some help, but I manage most of my personal care.
4 ( ) I need some help every day in most aspects of self care.
5 ( ) I do not get dressed, was with difficulty, and stay in bed.

Question 2 – Lifting

0 ( ) I can lift heavy objects without extra pain.
1 ( ) I can lift heavy objects, but it gives extra pain.
2 ( ) Pain prevents me from lifting heavy objects off the floor, but I can manage if they are on the table.
3 ( ) Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned.
4 ( ) I can only lift very light objects.
5 ( ) I cannot lift or carry anything at all.

Question 3 – Walking

0 ( ) Pain does not prevent me from walking any distance.
1 ( ) Pain prevents me from walking more than 1 hour.
2 ( ) Pain prevents me from walking more than 1/2 hour.
3 ( ) Pain prevents me from walking more than 10 minutes.
4 ( ) I can only walk a few steps at a time.
5 ( ) I am unable to walk.

Question 4 – Sitting

0 ( ) I can sit in any chair as long as I like.
1 ( ) I can only sit in my favorite chair as long as I like.
2 ( ) Pain prevents me from sitting more than 1 hour.
3 ( ) Pain prevents me from sitting more than 1/2 hour.
4 ( ) Pain prevents me from sitting more than 10 minutes.
5 ( ) Pain prevents me from sitting at all.

Question 5 – Standing

0 ( ) I can stand as long as I want without extra pain.
1 ( ) I can stand as long as I want but it gives me extra pain.
2 ( ) Pain prevents me from standing more than 1 hour.
3 ( ) Pain prevents me from standing more than 30 minutes.
4 ( ) Pain prevents me from standing more than 10 minutes.
5 ( ) Pain prevents me from standing at all.

Question 6 – Sleeping

0 ( ) I sleep well.
1 ( ) Pain occasionally interrupts my sleep.
2 ( ) Pain interrupts my sleep half of the time.
3 ( ) Pain often interrupts my sleep.
4 ( ) Pain always interrupts my sleep.
5 ( ) I never sleep well.

Question 7 – Sex Life

0 ( ) My sex life is unchanged.
1 ( ) My sex life is normal and causes some extra pain.
2 ( ) My sex life is nearly normal but is very painful.
3 ( ) My sex life is severely restricted by pain.
4 ( ) My sex life is nearly absent because of pain.
5 ( ) Pain prevents any sex life at all.

Question 8 – Social Life

0 ( ) My social and recreational life is unchanged.
1 ( ) My social and recreational life is unchanged but increases pain..
2 ( ) My social and recreational life is unchanged but severely increases pain.
3 ( ) Pain has restricted my social and recreational life.
4 ( ) Pain has severely restricted my social and recreational life.
5 ( ) I have no social life because of pain.

Question 9 – Traveling

0 ( ) I can travel anywhere without extra pain.
1 ( ) I can travel anywhere but it gives me extra pain.
2 ( ) Pain is bad but I mange traveling over 2 hours.
3 ( ) Pain restricts me to trips of less than 1 hour.
4 ( ) Pain restricts me to trips under 30 minutes.
5 ( ) Pain prevents me from traveling.

Question 10 – Reclining (Lying Down)

0 ( ) I do not have to recline because of my pain.
1 ( ) Pain causes me to recline for under 2 hours per day.
2 ( ) Pain causes me to recline for up to 4 hours per day.
3 ( ) Pain causes me to recline for up to 8 hours per day.
4 ( ) Pain causes me to recline for up to 12 hours per day.
5 ( ) Because of pain, I recline all day long.

L.A. ORTHOPAEDIC CENTER

Tae Shin, M.D.

Pain Medication Prescription Policy

All pain medication prescriptions from our office must be requested directly from Dr. Shin. During office hours, you may speak to a nurse at the office who will relay the message to Dr. Shin.

As one of Dr. Shin's patients, only Dr. Shin knows your medical condition. The On-Call physician who is available during after hours, does not know your medical condition, and is not allowed to prescribe pain medications.

Pain medications will not be called-in to a pharmacy after the office is closed. Pain medications will not be called-in to a pharmacy over the weekend. Therefore, you must call the office before your medication is finished. Please plan accordingly so that we may call a pharmacy during office hours before your medications are completed. We will do our best to facilitate the relief of your pains. Please understand that this policy exists to prevent complications from side effects of medications.

I have read and agree with the above policy.

Print name:______________________________

Signature:______________________________

Date:______________________________