Kanuru Interventional Spine & Pain Institute

3445 Ridge Road, Highland, IN 46322
Phone: (219) 838-1100
Fax: (219) 923-3501

Name: ______________________________ Age: ________ DOB: ____________

Gender: Male ☐ Female ☐ Home Phone: ________________ Cell/Work Phone: ______________

Referring Physician: ____________________________City: _________Phone: _______ Fax: ________

Primary _Physician: ____________________________ City: __ Phone: _____________ Fax: ________

Describe the areas your pain is located: Starts_______________________ Stops:_____________

Were you injured at work or in a motor vehicle accident? ☐ **Yes** ☐ **No (If yes Please fill out attached sheet)**

When/how did your pain start? ____

When is your pain most severe? ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Nighttime**

In a short statement, describe how your pain affects your life style: ______________________

____

Are you able to perform physical activity? ☐ Yes ☐ No - Explain: ________________________

<u>Check the words that best describe your pain</u>

☐ Sharp ☐ Shooting ☐ Dull ☐ Tingling ☐ Pulling
☐ Aching ☐ Hot ☐ Heavy ☐ Burning ☐ Cold
☐Numbness ☐ Cramping ☐ Constant ☐ Throbbing ☐ Intermittent
☐ Itching ☐ Stabbing ☐ Radiating ☐ Aggravating ☐ Other ________________

<u>What increases your pain? Please mark an (X) next to all that apply:</u>

☐ Physical Activity ☐ Walking ☐ Noise ☐ Sitting ☐ Financial concerns
☐ Cold Weather ☐ Stress ☐ Bending Over ☐ Standing ☐ Damp Weather
☐ Climbing stairs ☐ Family ☐ Lying down – Flat ☐ Anger ☐ Riding in a car
☐ Warm/hot water ☐ Coughing ☐ Lying on side ☐ Sneezing ☐ Other ____________

<u>What decreases your pain?</u> Please mark an (X) next to all that apply:

☐ Physical Activity ☐ Heating Pad ☐ Walking ☐ Socializing ☐ Massage
☐ Lying down – Flat ☐ Bath/Shower ☐ Music ☐ Deep Breathing ☐ Work
☐ Lying on side ☐ Watching TV ☐ Smoking ☐ Pain Pills ☐ Alcohol
☐ Ice/Cold Compress ☐ Other ______________________________

Please List any medication allergies: ____

Please List any food allergies: ____

Are you allergic to LATEX? ☐ Yes ☐ No **Are you allergic to IVP (x-ray) Dye?** ☐ Yes ☐ No

<u>Have you Been Treated for any of the following problems?</u>

☐ Thyroid Disease ☐ High Blood Pressure ☐ Liver Disease ☐ Asthma ☐ Drug abuse
☐ Heart Disease ☐ Difficult Swallowing ☐ Abdominal Pain ☐ Diabetes ☐ Alcohol abuse
☐ Chest Pain ☐ Change in Bowel Habits ☐ Emphysema ☐ Ulcers ☐ Hepatitis
☐ Cancer ☐ Difficulty Urinating ☐ Bleeding ☐ Cancer ☐ Anxiety
☐ Depression ☐ Epilepsy ☐ Pregnancy ☐ Arthritis ☐ Palpitations
☐ TIA or Stroke ☐ Shortness of Breathe ☐ Tachychardia ☐ Other ______________

<u>Please mark an (X) to all that apply to you sleeping habits:</u>

☐ I have trouble sleeping ☐ My Pain wakes me up ☐I have restless sleep

Date: ____________________________

Family History: (Check the box if the health problems apply to the perspective family member)

	Diabetes	High Blood Pressure	Heart Disease	Stroke	Back Pain	Mental Disorders	Rheumatoid Arthritis
Mother							
Father							
Grandmother							
Grandfather							

Please list all PAIN MEDICATIONS you are now taking? How long have you been taking each one?

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Please list all OTHER MEDICATIONS you are now taking? How long have you been taking each one?

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Please list all Surgeries performed on you, and the year they were performed:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Are you: ☐ Married ☐ Single ☐ Divorce ☐ Widowed **How many children?**____________

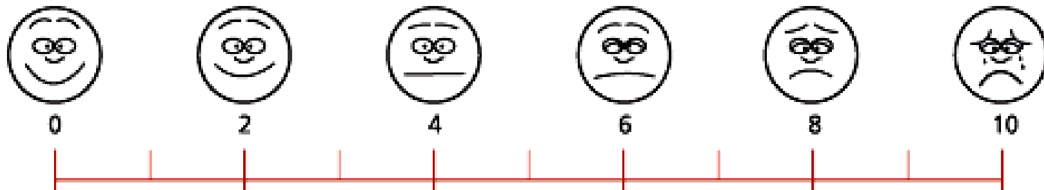
Please list the highest level of education you've completed: ________________________________

What is your Occupation? ________________ **What is your height?** _____ **You're weight?** ____

Do You.....

Smoke ☐ Yes ☐ No **Drink Alcohol** ☐ Yes ☐ No **Use recreational Drugs** ☐ Yes ☐ No

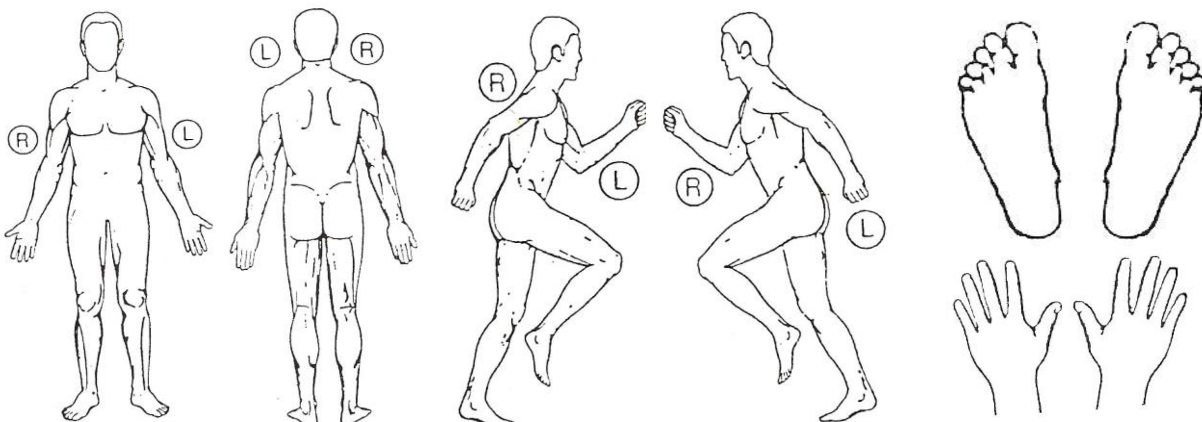
If "yes", how much If "yes", ☐ Daily ☐ Socially



1 3 5 7 9

No Pain **Mild Pain** **Moderate Pain** **Severe** **Very Severe** **Worst Possible**

ON THE FIGURES BELOW, COLOR IN THE AREAS IN WHICH YOU ARE EXPERIENCING PAIN



Any concerns or questions related to this visit:____

Signature ______________________________ Date form completed ____________________