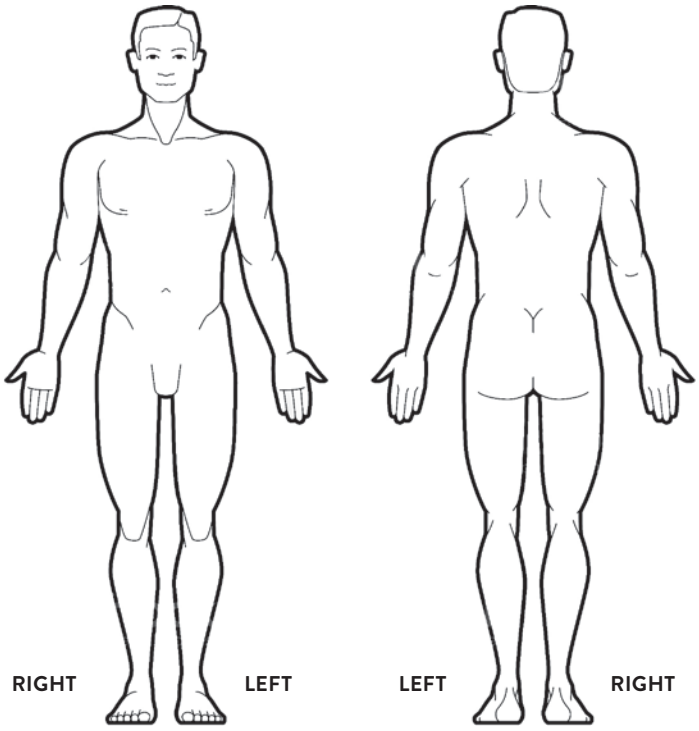
RASOULI
SPINE

PATIENT I.D.



Where is your pain now?

Mark the areas on your body using the appropriate symbols to describe your symptoms.

TYPE OF PAIN	SYMBOL
Ache	<<<<<<<<<<<<<<
Numbness	0 0 0 0 0 0 0 0 0
Pins & Needles	⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠⊠
Burning	xxxxxxxxxxxxxxx
Radiating Pain	///////////////////////////

How bad is your pain?

Neck Pain _____ % Back Pain _____ %

Arm Pain _____ % Leg Pain _____ %

Total 100 % Total 100 %

How much pain in general can you tolerate?

0 1 2 3 4 5 6 7 8 9 10

How bad is your pain now?

0 1 2 3 4 5 6 7 8 9 10

THE DURATION OF PAIN

[ ] Continuous [ ] Positional [ ] Intermittent (On/Off) [ ] Unable to Rate

HAVE YOU TAKEN PAIN MEDICATION IN THE PAST 24 HOURS?

[ ] Yes [ ] No

9090 WILSHIRE BLVD. SUITE 101, BEVERLY HILLS, CA, 90211 **OFFICE** 310 421 0066 **FAX** 888 251 0362 **E-MAIL** INFO@RASOULISPINE.COM **RASOULISPINE.COM**

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PERSONAL INFORMATION

Last Name:_____ First Name:_____

Age:_____ Date of birth:_____ Occupation: _____ [ ] Not working

SOCIAL HISTORY

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Do you live alone: [ ] Yes [ ] No

How many children do you have? _____

Will you have a caregiver to assist you if surgery is needed? [ ] Yes [ ] No

Are you currently working? [ ] Yes [ ] No

Have you lost work due to your back problem? [ ] Yes [ ] No

Do you have stairs in your home? [ ] Yes [ ] No

Do you think you are at risk for a fall? [ ] Yes [ ] No

CURRENT PROBLEMS

Date symptoms began: _____

Chief complaint or reason for visit: _____

Cause of present problem (e.g. work related injury, auto accident, slip-and-fall, etc.): _____

What favorite activities does your pain prevent?: _____

Can you care for yourself (i.e. dressing, eating, toileting, standing up, etc.) _____

Other difficult functions include: _____

PAST HISTORY

Past or ongoing medical problems (e.g. high blood pressure, stroke, diabetes, heart condition, cancer, etc.):

(If more space is needed, please attach on a separate sheet.)

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Previous Surgeries

Name of operation	Date

Other Information

Do you smoke? [ ] Yes [ ] No Number of cigarettes per day _____

Do you drink alcohol? [ ] Yes [ ] No Number of drinks per day _____

Have you had imaging in the last 3 months?

[ ] Yes [ ] No [ ] MRI [ ] CT Scan [ ] X-rays

Allergies

Please list all allergies and response such as rash, itching, difficulty breathing, or unknown:

Drug name	Reaction

Medications

Please list all current medications, over the counter drugs, vitamins and herbals.

Please give us the total number of "as needed" medication taken in a 24-hour period.

Name	Dosage / Amount	Time of day	Total taken in 24 hours.

Signature _____ Date _____ Time _____