2585 Pacific Coast Highway
Torrance CA, 90505

Munish Lal, MD

Spine & Pain Care Specialist

Tel (424) 360-0155
Fax (424) 488-1364

Please complete all pages of this intake form. We rely on its completeness to provide you with the best possible care.
Completing this form helps **YOU.**
Your handwritten answers help to support your treatment so please be clear, thorough, and as accurate as possible.

Patient Information

Your name:_____, _____Date of Birth: _____ Age:
LAST name **FIRST** name

Today's date: _____Who/What referred you_____

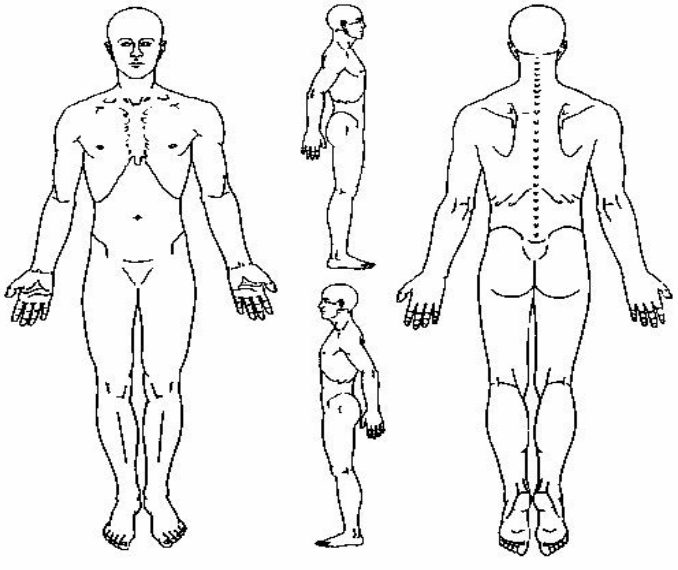
Pain History

Chief Complaint (The MAIN pain issue)? _____

When did this pain begin (or what is the date of injury)? _____

DRAW the appropriate symbol in the painful area. ***If the pain radiates***, draw an arrow from where it starts to where it stops.

SYMBOL:
Pins and Needles = 000000
Stabbing = / / / / / /
Burning = xxxxxx
Deep Ache = zzzzzz



On a pain scale from 0-10, 0 meaning no pain, and 10 being the worst pain imaginable. How would you rate your pain?

Right Now _____The Best It Gets _____The Worst It Gets_____

****** If your pain score is different at different areas, please place the individual pain score next to each area.******

Since your pain began how has it changed? __ Improved __ Worsened __ Stayed the same

When is your pain at its worst?

__ Mornings __ Daytime __ Evenings __ Middle of night __ Always the same

How often does the pain occur?

__ Intermittent (comes and goes) __ Changes in severity but always present __ Constant

2585 Pacific Coast Highway
Torrance CA, 90505

Munish Lal, MD

Spine & Pain Care Specialist

Tel (424) 360-0155
Fax (424) 488-1364

Personal Injury Information -

The more **detail you write**, the more we are able to help **YOU.**
Your handwritten answers **help to support you** and your treatment so please be clear, thorough, and as accurate as possible.

Injury History

1. Injury from (circle or write): car accident, slip and fall, motorcycle, car vs pedestrian, car vs bicycle,
   a. If in car were you: wearing seatbelt, not wearing seatbelt
   b. If in car were you: driver, front passenger, right rear, left rear, mid rear?

2. In what city did this happen?_____

3. Describe in detail how your body, head, arms, hands, legs, feet were positioned before the incident:

_____

_____

4. Describe the incident (if car, describe each impact, impact location, car motions; rear-ended, T-boned on left/right, side-swiped on left/right, head on, head-on left, head-on right, hit car in-front, hit median, hit pole, spun clockwise/counterclockwise):

_____

_____

_____

_____

5. Describe in detail how your body, head, arms, hands, legs, feet were shifted/impacted/twisted when the incident occurred:

_____

_____

_____

_____

6. ***Immediately*** following the injury, did you experience nausea, vomiting, dizziness, blurred vision, etc? Please list:

_____

_____

7._____ Did you go to a hospital that day? _____ Name? _____ .
8._____ What city?_____ . Ambulance? __Y__ N

IF NOT, when did you first see a doctor? _____

9. List doctors, or types of doctors, you've seen (not ER), and the approximate dates you saw them:

_____

_____

10. Have you ever had pain/injury in this/these area(s) ***BEFORE*** this injury? __ Yes __No. Explain, include **year(s) and treatments**:

_____

_____

10a *Did that pre-existing pain get better? __ Yes __ No *Did that pre-existing pain resolve completely? __ Yes __ No

10b What was your typical pain level in the weeks/months before this new injury (0-10)? _____

*****Answers to questions on page 2 (next page) apply ONLY SINCE your injury.*****

*****If due to Personal Injury, please provide information on this page that applies ONLY SINCE your injury.*****

	Better	Worse	Body Area
Bending Backward	☐	☐	
Bending Forward	☐	☐	
Changes in Weather	☐	☐	
Climbing Stairs	☐	☐	
Coughing/Sneezing	☐	☐	
Driving	☐	☐	
Lifting Objects	☐	☐	
Looking up/down	☐	☐	
Looking side to side	☐	☐	
Rising from sitting	☐	☐	
Sitting	☐	☐	
Standing	☐	☐	
Walking	☐	☐	
Other:			

	Helped	Worsened	Same	# of MONTHS?
Medications	☐	☐	☐	
Physical Therapy	☐	☐	☐	
Chiropractic	☐	☐	☐	
Roller Table	☐	☐	☐	
Electric Stim/TENS	☐	☐	☐	
Heat/Ice	☐	☐	☐	
Massage Therapy	☐	☐	☐	
Acupuncture	☐	☐	☐	
Brace Support	☐	☐	☐	
Cognitive Therapy	☐	☐	☐	
Other				

Associated Symptoms

	No	Yes	LOCATION
Numbness (can't feel skin)	☐	☐	
Weakness in the arm/leg	☐	☐	
Can't hold Bladder	☐	☐	
Can't hold Bowels	☐	☐	

Limitations

Have you experienced any ***restrictions*** or ***difficulties*** with any **ACTIVITIES OF DAILY LIVING**, SOCIAL ACTIVITIES, THINGS YOU DO FOR FUN because of your current condition? ☐ Yes ☐ No *****Describe in detail and be specific*****
(For example bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, sports, etc.)

Interventional Pain Treatment History (if used, please indicate date you last received each) - ☐

	Dates/Years
☐ Epidural **Steroid** (*not childbirth*) Injection – (circle levels): Cervical/Thoracic/Lumbar	
☐ Facet Injections/ Medial Branch Blocks - (circle levels): Cervical/Thoracic/Lumbar	
☐ Joint Injection – Joint(s):	
☐ Trigger Point Injections Where?	
☐ Other -	

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

☐ MRI of the: Date:
☐ X-Ray of the: Date:
☐ CT Scan of the: Date:
☐ EMG/NCV study of the: Date:
☐ Other Diagnostic Testing: Date:

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____

Cardiovascular/Hematologic
- ❑ Heart Attack
- ❑ High Blood Pressure

Gastrointestinal
- ❑ GERD (Acid Reflux)
- ❑ Stomach Ulcers
- ❑ Constipation

Respiratory
- ❑ Asthma
- ❑ Emphysema/COPD

Urological
- ❑ Chronic Kidney Disease
- ❑ Urinary Incontinence

Neuropsychological
- ❑ Peripheral Neuropathy
- ❑ Seizures
- ❑ Depression
- ❑ Anxiety
- ❑ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat
- ❑ Headaches
- ❑ Hyperthyroidism
- ❑ Hypothyroidism

Musculoskeletal/Rheumatologic
- ❑ Fibromyalgia
- ❑ Arthritis
- ❑ Osteoporosis

Other Diagnosed Conditions

_____

_____

❑ **I have no significant Past Medical History**

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) _____ Date?_____
2) _____ Date?_____
3) _____ Date?_____
4) _____ Date?_____
5) _____ Date?_____

❑ **I have NEVER had any surgical procedures performed.**

Medications

Please list all medications you are ***CURRENTLY*** taking including vitamins. Attach additional sheet if required:

	Medication Name	**Dose**	**Frequency**
1)			
2)			
3)			
4)			
5)			

*** Are you currently taking any **blood thinners** or anti-coagulants? ❑ Yes ❑ No Name(s): _____

Please list all ***PAST*** pain medications that you have been on at any point ***for your current pain complaints.***

	Medication Name		
1)			
2)			
3)			

Allergies

Please list all medications you are allergic to: ❑ None

	Medication Name	Allergic Reaction
1)		
2)		
3)		

Topical Allergies: ❑ Latex ❑ Iodine ❑ Tape ❑ IV Contrast/Iodine ❑ Other

Family History

Mark all appropriate diagnoses as they pertain to your first-degree relatives:

❑ Cancer ❑ Diabetes ❑ Headaches/Migraines

❑ High Blood Pressure ❑ Osteoporosis ❑ Rheumatoid arthritis

❑ **No significant family medical history**

Social History

Occupation:_____ If none, when was the last time you worked?_____

❑ Temporary Disability ❑ Permanent Disability ❑ Retired ❑ Unemployed

Are you currently under worker's compensation? ❑ No ❑ Yes

Is there an ongoing lawsuit related to your visit today? ❑ No ❑ Yes

Who is in your current household?_____

Tobacco Use:

❑ Never used ❑ Current user ❑ Former user ❑ Packs per day? _____ for _____years?_____❑ Quit Date:_____

Alcohol Use:

❑ Never used ❑ Social Use ❑ History of alcoholism ❑ Current alcoholism ❑ Daily use of alcohol

Illegal Drug Use (not including marijuana):

❑ No illegal drug use ❑ Current illegal drug use ❑ Formerly used illegal drugs

Have you ever abused prescription medications? ❑ Yes ❑ No

Review of Systems

** Mark the following symptoms you are ***experiencing today***:

Constitutional:
❑ Chills
❑ Difficulty sleeping
❑ Easy bruising
❑ Fatigue
❑ Fevers
❑ Low sex drive
❑ Unexplained Weight Gain
❑ Unexplained Weight Loss

Ears/Nose/Throat/Neck:
❑ Dental Problems
❑ Earaches
❑ Hearing Problems
❑ Nosebleeds
❑ Sinus problems

Cardiovascular:
❑ Chest Pain
❑ Bleeding Disorder
❑ Blood Clots
❑ Fainting
❑ Palpitations

Eyes:
❑ Blurred vision
❑ Loss of vision

Gastrointestinal:
❑ Nausea/Vomiting
❑ Diarrhea
❑ Constipation
❑ Acid Reflux
❑ Abdominal Cramps

Respiratory:
❑ Cough
❑ Wheezing
❑ Shortness of breath

Musculoskeletal:
❑ Joint Stiffness
❑ Joint Swelling
❑ muscle spasms

Genitourinary/Nephrology:
❑ Flank Pain
❑ Blood in Urine
❑ Painful Urination
❑ Change in Urine Flow/Frequency/Volume

Neurological:
❑ Dizziness
❑ Headaches
❑ Tremors
❑ Seizures

Psychiatric:
❑ Depressed Mood
❑ Feeling Anxious
❑ Stress Problems
❑ Suicidal Thoughts
❑ Suicidal Planning
❑ Thoughts of Harming Others

❑ All other review of systems negative

Who is filling out this questionnaire? ❑ Self ❑ Spouse ❑ Other _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature_____ Date_____ Reviewer_____Date