REGENERATIVE
SPINE & JOINT CENTER

BORIS TEREBUH, MD
www.RegenerativeSpineAndJoint.com
6860 Perimeter Drive, Suite A
Dublin, Ohio 43016
(614) 389-3089, (614) 389-3876 fax

Medical History Form

Name:_____ Today's Date: _____ (page 1 of 4)

Age:_____ Date of Birth:_____ Dominant Hand: **R** **L** Gender: **Male** **Female** **Other** _____

Who referred you? _____ Primary Care Provider's name? _____

① Are your symptoms related to a vehicle accident or personal injury **YES** **NO** If yes, describe briefly: _____

② Is a lawyer involved in this issue? **YES** **NO** ③ Did a work injury cause your symptoms? **YES** **NO**

• • • If YES to any of the 3 questions in this box then stop filling in this form & call our office to discuss • • •

PRIMARY SYMPTOM

Where is your **PRIMARY** symptom located? _____

How long ago did your **PRIMARY** symptom begin? _____

How did your **PRIMARY** symptom begin? (circle) **Gradually** **Suddenly**

Your **PRIMARY** symptom is: (circle any) **Constant** **Intermittent** **Worsening** **Improving** **Plateaued**

Do you have **weakness?** **YES** **NO** (if yes, is weakness **Constant** or **Intermittent** or **Posture Dependent**?)

Check mark ✓ how each activity impacts your primary symptom:	While Sitting	While Standing	Moving Sit to Stand	Walking	Lying on Belly (prone)	Lying on Back (supine)	Lying on Left Side	Lying on Right Side	Pushing Shopping Cart	Everything	Nothing
Aggravates											
No Change											
Relieves											

SECONDARY SYMPTOM (leave section blank if no **Secondary Symptom**)

Where is your **SECONDARY** symptom located? _____

How long ago did your **SECONDARY** symptom begin? _____

How did your **SECONDARY** symptom begin? (circle) **Gradually** **Suddenly**

Your **SECONDARY** symptom is: (circle any) **Constant** **Intermittent** **Worsening** **Improving** **Plateaued**

Do you have **weakness?** **YES** **NO** (if yes, is weakness **Constant** or **Intermittent** or **Posture Dependent**?)

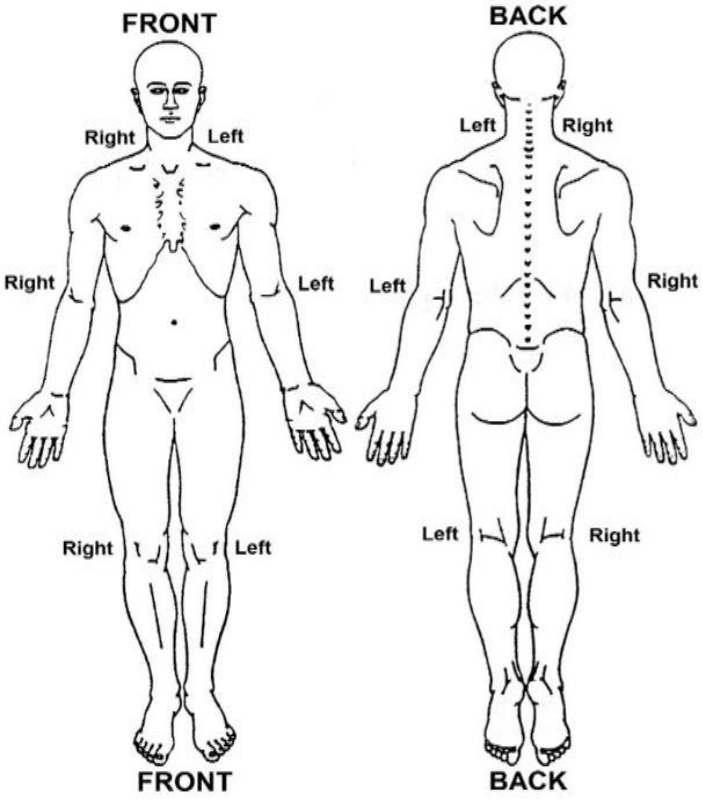
Check mark ✓ how each activity impacts your secondary symptom:	While Sitting	While Standing	Moving Sit to Stand	Walking	Lying on Belly (prone)	Lying on Back (supine)	Lying on Left Side	Lying on Right Side	Pushing Shopping Cart	Everything	Nothing
Aggravates											
No Change											
Relieves											

Brief Pain Inventory (short form)

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain during the past week? ◯**Yes** ◯**No**

2) Mark the parts on your body where you feel symptoms. Include all affected areas. Use any of these symbols: Put an **X** on the area that hurts the most.

Ache ○ ○ ○ **Burning** > > > **Pins & Needles** • • • •
Numbness + + + **Stabbing** = = =



3) Rate your pain by circling the one number that is your pain at its **HIGEST LEVEL** in the past week.

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄No Pain Pain as bad as you can imagine►

4) Rate your pain by circling the one number that is your pain at its **LOWEST LEVEL** in the past week.

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄No Pain Pain as bad as you can imagine►

5) Rate your pain by circling the one number that represents how much pain you have on **AVERAGE**.

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄No Pain Pain as bad as you can imagine►

6) Rate your pain by circling the one number that represents how much pain you have **RIGHT NOW**.

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄No Pain Pain as bad as you can imagine►

7) What interventions are you receiving for your pain?

Medications (anti-inflammatory) _____
Medications (steroid) _____
Medications (muscle relaxer) _____
Medications (pain reliever) _____
Medications (opioid) _____
Medications (other) _____
Injections_____
Physical Therapy _____
Chiropractic Care _____
Other _____

8) In the past week, how much **RELIEF** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
◄No Relief Complete Relief►

9) Circle the one number that describes how **PAIN HAS INTERFERED** (during the past week) with your:

A. **General Activity**
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄Does not Interfere Completely Interferes►

B. **Mood**
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄Does not Interfere Completely Interferes►

C. **Walking Ability**
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄Does not Interfere Completely Interferes►

D. **Normal Work** (work outside home and housework)
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄Does not Interfere Completely Interferes►

E. **Relations with Other People**
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄Does not Interfere Completely Interferes►

F. **Sleep**
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄Does not Interfere Completely Interferes►

G. **Enjoyment of Life**
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
◄Does not Interfere Completely Interferes►

Circle any of the following diagnostic studies you have undergone for your current symptoms:

	Where (Facility / Location)	Date
Plain X-ray	_____	_____
CT Scan	_____	_____
MRI	_____	_____
Bone Scan	_____	_____
EMG	_____	_____
Discogram	_____	_____

Have you undergone any of the treatments listed below to try to resolve your symptoms? Check mark ✓ your responses.

		Date of 1st Treatment	Date of Last Treatment	Helpful	Not Helpful	Made Me Worse
Chiropractic Care	**YES NO**	_____	_____	_____	_____	_____
Acupuncture	**YES NO**	_____	_____	_____	_____	_____
Epidural Injections	**YES NO**	_____	_____	_____	_____	_____
Facet Joint Injections	**YES NO**	_____	_____	_____	_____	_____
Radiofrequency Ablation (RFA)	**YES NO**	_____	_____	_____	_____	_____
PRP or Stem Cell Inject.	**YES NO**	_____	_____	_____	_____	_____
Trigger Point Injections	**YES NO**	_____	_____	_____	_____	_____
Aquatic Therapy	**YES NO**	_____	_____	_____	_____	_____
Physical Therapy	**YES NO**	_____	_____	_____	_____	_____
Independent Exercises	**YES NO**	_____	_____	_____	_____	_____
Traction	**YES NO**	_____	_____	_____	_____	_____
TENS Unit	**YES NO**	_____	_____	_____	_____	_____
Other Treatment: _____		_____	_____	_____	_____	_____

List all of the physicians and/or chiropractors you have consulted for your present condition:_____

_____

REVIEW OF SYSTEMS *****Circle All That Apply Right Now*****

Allergy & Immunology: list all medication allergies or intolerances & include the reaction to each drug: _____

_____ _____ _____ _____ _____ _____

X-ray dye allergy? **YES NO** Latex allergy? **YES NO** ChloraPrep (chlorhexidine) allergy? **YES NO** Gentamycin allergy? **YES NO**

Do you have an infection anywhere in your body currently? **YES NO** If yes what infection? _____

Are you currently taking antibiotic, antiviral or antifungal medications? **YES NO** If yes what is the stop date? _____

Have you had recent dental work, or will you have upcoming dental work? **YES NO** If yes what was/is the date? _____

Musculoskeletal: **joint instability** **joint swelling** **joint stiffness** **muscle swelling** **TMJ syndrome**

Neurologic: **seizures** **tremor** **speech difficulty** **face droop** **chronic headache**

Psychiatric: **anxiety** **depression** **hallucinations** **addictions** **phobias**

Constitutional: **fevers** **chills** **night sweats** **unexplained weight loss** **can't fall asleep** **can't stay asleep**

Genitourinary: **painful urine** **blood in urine** **frequent urine** **stress urine incontinence** **total urine incontinence**

For Females Only: Are you, or could you be **pregnant?** **YES NO**

Gastrointestinal: **nausea** **vomiting** **diarrhea** **constipation** **bowel incontinence**

Cardiovascular: **short of breath while active** **chest pressure** **excessive sweating** **fainting** **leg swelling**

Respiratory: **short of breath at rest** **productive cough** **coughing blood** **wheezing** **sleep apnea**

Skin: **skin color change** **rash** **itching** **hair growth change** **nail growth change**

Endocrine: **excessive urine** **excessive thirst** **cold intolerance** **heat intolerance** **excessive hair growth**

Medications: Which medications are you taking **NOW** for your **current symptoms**? Circle one of these symbols to indicated how each medication works for you: very helpful ↑ partially helpful ≈ not helpful ↓ causes side effects Ø

①↑≈↓Ø_____	②↑≈↓Ø_____	③↑≈↓Ø_____	④↑≈↓Ø_____
⑤↑≈↓Ø_____	⑥↑≈↓Ø_____	⑦↑≈↓Ø_____	⑧↑≈↓Ø_____

Have you tried or are you currently taking? (circle any that apply) Tylenol ↑≈↓Ø acetaminophen ↑≈↓Ø ibuprofen ↑≈↓Ø Advil ↑≈↓Ø Motrin ↑≈↓Ø Aleve ↑≈↓Ø Naproxen ↑≈↓Ø or any other over-the-counter (OTC) or prescription anti-inflammatory medications? (write in any others) ①↑≈↓Ø_____ ②↑≈↓Ø_____ ③↑≈↓Ø_____

In the **past 12 months** have you taken **steroid tablets** or received **steroid injections**? **YES** **NO** (circle any that apply)
Cortisone ↑≈↓Ø Prednisone ↑≈↓Ø Methylprednisolone ↑≈↓Ø Medrol Dose Pack ↑≈↓Ø Depomedrol ↑≈↓Ø Kenalog ↑≈↓Ø Celestone ↑≈↓Ø other steroid ↑≈↓Ø_____
How many steroid treatments in the past 12 months? _____ When was the last steroid treatment? _____

Which medications have you taken in the **PAST** (but are no longer taking) for your **current symptoms**?

①↑≈↓Ø_____	②↑≈↓Ø_____	③↑≈↓Ø_____	④↑≈↓Ø_____
⑤↑≈↓Ø_____	⑥↑≈↓Ø_____	⑦↑≈↓Ø_____	⑧↑≈↓Ø_____

Which medications or supplements are you taking now for **other** medical conditions?

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Past Medical History:

Circle any medical conditions that apply to you:

Osteoporosis(penia)	Diabetes (____ yrs.)	Pacemaker	Blood Vessel Disease	Emphysema
Stomach Ulcers	Kidney Disease	Coronary Artery Disease	Stroke or Blood Clots	Asthma
Gastric Reflux	High Cholesterol	Congestive Heart Failure	Neurological Disease	Depression
Thyroid Disease↓↑	Hepatitis	Atrial Fibrillation	Seizures	Anxiety
Skin Disorders	Liver Disease	High Blood Pressure	Fibromyalgia	Gout
Cancer (what kind) _____		Heart Attack	Arthritis or Rheumatoid	HIV / AIDS
		Drug or Alcohol Addiction	Other Conditions: _____	

_____ _____ _____ _____

Past Surgical History: Please list all previous surgeries:

[Surgery_____ Date_____] [Surgery_____ Date_____] [Surgery_____ Date_____]
[Surgery_____ Date_____] [Surgery_____ Date_____] [Surgery_____ Date_____]
[Surgery_____ Date_____] [Surgery_____ Date_____] [Surgery_____ Date_____]

Family History: List any medical conditions that exist in your blood relatives and identify their relationship to you:

_____ _____ _____ _____

Social History:

Are you currently (please circle): **Single** **Married** **Separated** **Divorced** **Widow / Widower** **Other**
If married, what is the age and health status of your spouse? Age:_____ Health Status: _____
Do you have children? **YES** **NO** How many:_____ Ages: _____
What was the last school grade you completed?_____ List other degrees: _____
Do you drink alcoholic beverages? **YES** **NO** which? (circle) **beer** **wine** **liquor** Drinks per day:_____
Do you use nicotine products? **YES** **NO** which? (circle) **cigarettes** (packs/day: ___) **smokeless** **vapor** **cigars** **pipe**

Occupational History: Are you retired? **NO** **YES** (If yes, when?) _____
Name of employer:_____ **part time** or **full time** How long: _____
Job Title:_____ Shift: **1st** **2nd** **3rd** Date you last worked: _____
Are you working with restrictions? **YES** **NO** If yes what are your restrictions? _____
Have you been laid off? **YES** **NO** If yes, is the layoff (circle): **Temporary** **Permanent** **Seasonal**
Are you on disability? **YES** **NO** If yes (circle) **Short Term** **Long Term** **Social Security** Other_____