Center for Nerve Injury and Paralysis
Peripheral Nerve & Spine Health History Form

Welcome to the Center for Nerve Injury and Paralysis at Washington University. To help us treat you, please fill this form out completely.

Your Name:_____ **Today's Date:** _____

Your date of birth: _____ **Your age:** _____

Who referred you to us: _____

Who is your primary care physician: _____
(if same as referring, check here: ☐):

List any other physicians you would like us to send our notes to:

_____

What problem are we seeing you for today:

_____
_____
_____
_____

Are you (please circle one): right-handed, left-handed, ambidextrous

Allergies to medications: (check here if you do NOT have any known allergies to medications: ☐)

_____
_____
_____

	YES	NO	UNKNOWN
Do you have an allergy to latex?.....	☐	☐	☐

Medications: (please list all medications you are now taking including over-the-counter medications such as ibuprofen). Indicate which medications are for this problem by placing a check mark in the box next to the medication.

Name	Dose		Name	Dose	
_____	_____	☐	_____	_____	☐
_____	_____	☐	_____	_____	☐
_____	_____	☐	_____	_____	☐
_____	_____	☐	_____	_____	☐
_____	_____	☐	_____	_____	☐
_____	_____	☐	_____	_____	☐
_____	_____	☐	_____	_____	☐
_____	_____	☐	_____	_____	☐

Past medical history

Active medical problems. These are problems for which you are currently taking medication or are seeing another physician, such as high blood pressure, heart problems, etc...): **(check here if none: ☐)**

_____
_____
_____

Past medical problems. Have you ever been treated for, or taken medications for, any of the following medical conditions:

YES	NO	
☐	☐	Diabetes (high blood sugars)
☐	☐	Hypertension (high blood pressure)
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Congestive heart failure
☐	☐	Asthma
☐	☐	Tuberculosis
☐	☐	Glaucoma
☐	☐	Osteopenia (mild weakening of the bones)
☐	☐	Osteoporosis
☐	☐	Stroke/TIA
☐	☐	Seizures
☐	☐	HIV/AIDS
☐	☐	Hepatitis
☐	☐	Bleeding disorder
☐	☐	Depression

Past surgical history:

Previous surgery related to this problem (with dates): (check here if none: ☐)

_____
_____
_____
_____

All other surgeries (with dates): Please list any other surgeries you have had, including tonsillectomy, gallbladder removal (cholecystectomy), hysterectomy, etc...**(check here if none: ☐)**

_____
_____
_____
_____

Family history: (please indicate any major medical problems in your family)

YES	NO	
☐	☐	Diabetes
☐	☐	Stroke
☐	☐	Hypertension
☐	☐	Heart disease/heart attack
☐	☐	Cancer
☐	☐	Bleeding Disorders

Other family medical history:

_____
_____
_____
_____

Please answer yes or no to each of the following:

	YES	NO
Is this a workman's compensation case?.....	☐	☐
Is this related to an injury or car accident?.....	☐	☐
Are you currently involved in any litigation or lawsuits?	☐	☐
Have you consulted a lawyer about your injury/problem?	☐	☐
Have you ever seen a nerve surgeon before?.....	☐	☐
For your current problem?.....	☐	☐

Which surgeons have you seen?_____

Personal/social history:

Tobacco use: ☐ Never

☐ Previously used
Year quit: _____
packs/day when using: _____

☐ Recently quit
#packs/day when using: _____

☐ Current:
Number of years using: _____
#packs/day: _____
Have you ever quit before? _____

☐ Other nicotine use (chewing tobacco, cigar, pipe)

Alcohol use:
☐ Never/rarely
☐ Occasionally/socially
☐ Moderate (2 drinks/day on average)
☐ Heavy (more than 2 drinks/day on average)

Marital status:
☐ Single
☐ Married
☐ Separated
☐ Widowed
☐ Divorced
☐ Domestic Partner

Work status: ☐ Currently employed
Occupation:_____

☐ Not currently employed
☐ Retired
☐ On disability
When disabled? _____
Reason for disability? _____

☐ Is this a workers compensation case?

Review of systems:

Overall, do you feel:

- ☐ **Healthy**
- ☐ **As well as can be expected**
- ☐ **Terrible**

In the past 30 days, have you had any of the following symptoms?:

YES	NO	
☐	☐	**Tiredness/fatigue**
☐	☐	**Fevers**
☐	☐	**Chills**
☐	☐	**Sweat heavily at night (night sweats)**
☐	☐	**Recent weight loss (unintentional)**
☐	☐	**Headache**
☐	☐	**Chest pain**
☐	☐	**Palpitations (heart racing)**
☐	☐	**Shortness of breath**
☐	☐	**Difficulty breathing during exertion**
☐	☐	**Cough**
☐	☐	**Difficulty swallowing**
☐	☐	**Heartburn (acid reflux)**
☐	☐	**Nausea**
☐	☐	**Vomiting**
☐	☐	**Incontinence of bowels (unable to restrain bowels)**
☐	☐	**Incontinence of bladder (unable to restrain urine)**
☐	☐	**Easy bleeding**
☐	☐	**Easy bruising**
☐	☐	**Diffuse joint pains (arthralgias)**
☐	☐	**Muscle aches**
☐	☐	**Anxiety**
☐	☐	**Depression**

Description of Problems (if applicable)

What procedures have you had for the treatment of your current problem? Please check all that apply.

☐	Surgery	☐	Nerve Blocks	☐	Steroid Injections
☐	Physical Therapy	☐	Tens Unit	☐	Psychological Counseling
☐	Relaxation Training	☐	Biofeedback	☐	Chiropractic Treatment

Other:_____

Pain Questionnaire

PAIN: please answer for each area of pain (e.g. neck, back, hand, etc.)
(check here if you do not have pain: ☐)

1. When did your pain begin? _____
2. Is the pain: ☐ Improving ☐ Staying the Same ☐ Getting Worse
3. Is the pain: ☐ Constant ☐ Does it come and go
4. **Where** does your pain radiate (e.g. Down your arm or leg? Into your hand? Which fingers?)

5. If your pain is in your neck and arm(s), what percentage is in your neck and what percentage is in your arm(s)?
   _____ %Neck _____ %Arm(s)
6. If your pain is in your back and leg(s), what percentage is in your back and what percentage is in your leg(s)?
   _____ %Back _____ %Leg(s)

7. Pain is difficult to describe. Circle the words that best describe your symptoms:

Burning Throbbing Aching Stabbing Tingling Twisting Squeezing

Cramping Cutting Shooting Numbing Vague Stinging Indescribable

Pulling Smarting Pressure Coldness Dull Other: _____

8. Which side hurts more? ☐ Left ☐ Right
9. Describe what makes your pain worse.
10. Describe what makes your pain better.
11. How far can you walk before you need to sit down and rest?
12. How far could you walk 1 year ago, before you needed to sit down and rest?

Level of symptoms: place a mark through the line to indicate the level of your pain, if zero is no pain and the end of the line is the most severe pain you can imagine having.

13. Mark your **average** level of pain in the last **month**

No Pain Worst pain imaginable

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

14. Mark your **worst** level of pain in the last **week**

Right

No Pain Worst pain imaginable

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Left

No Pain Worst pain imaginable

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Mark on this scale how your pain has affected your quality of life:

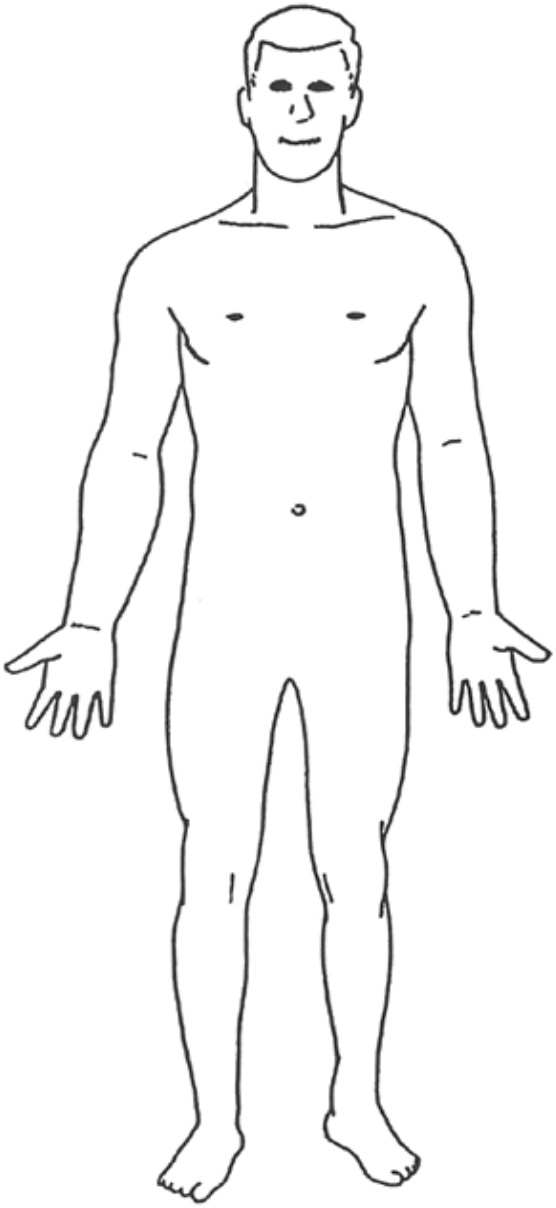
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Very little A large amount

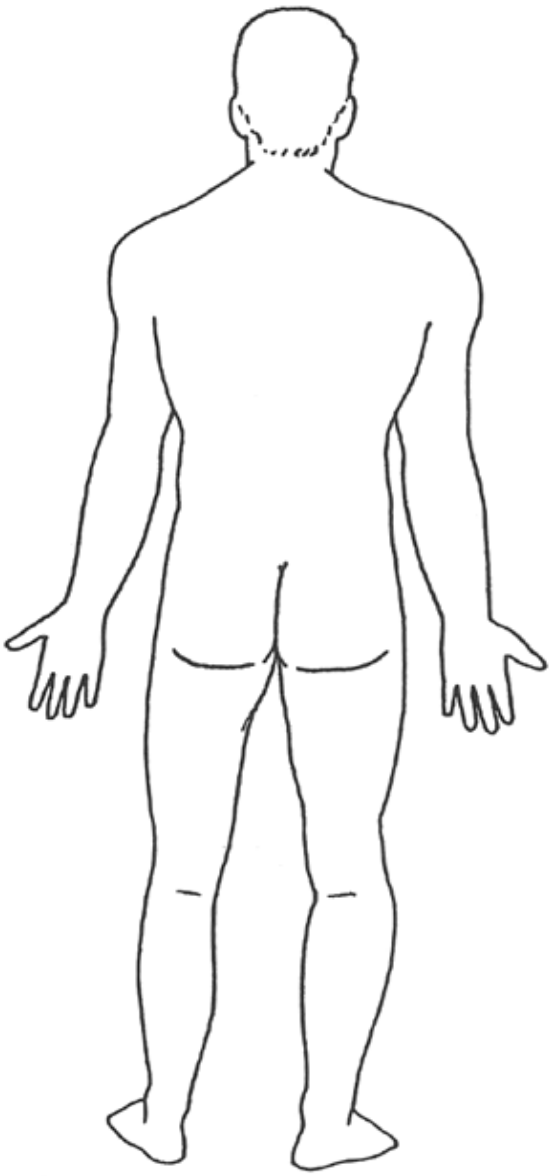
15. Where is your pain? Where is your numbness?

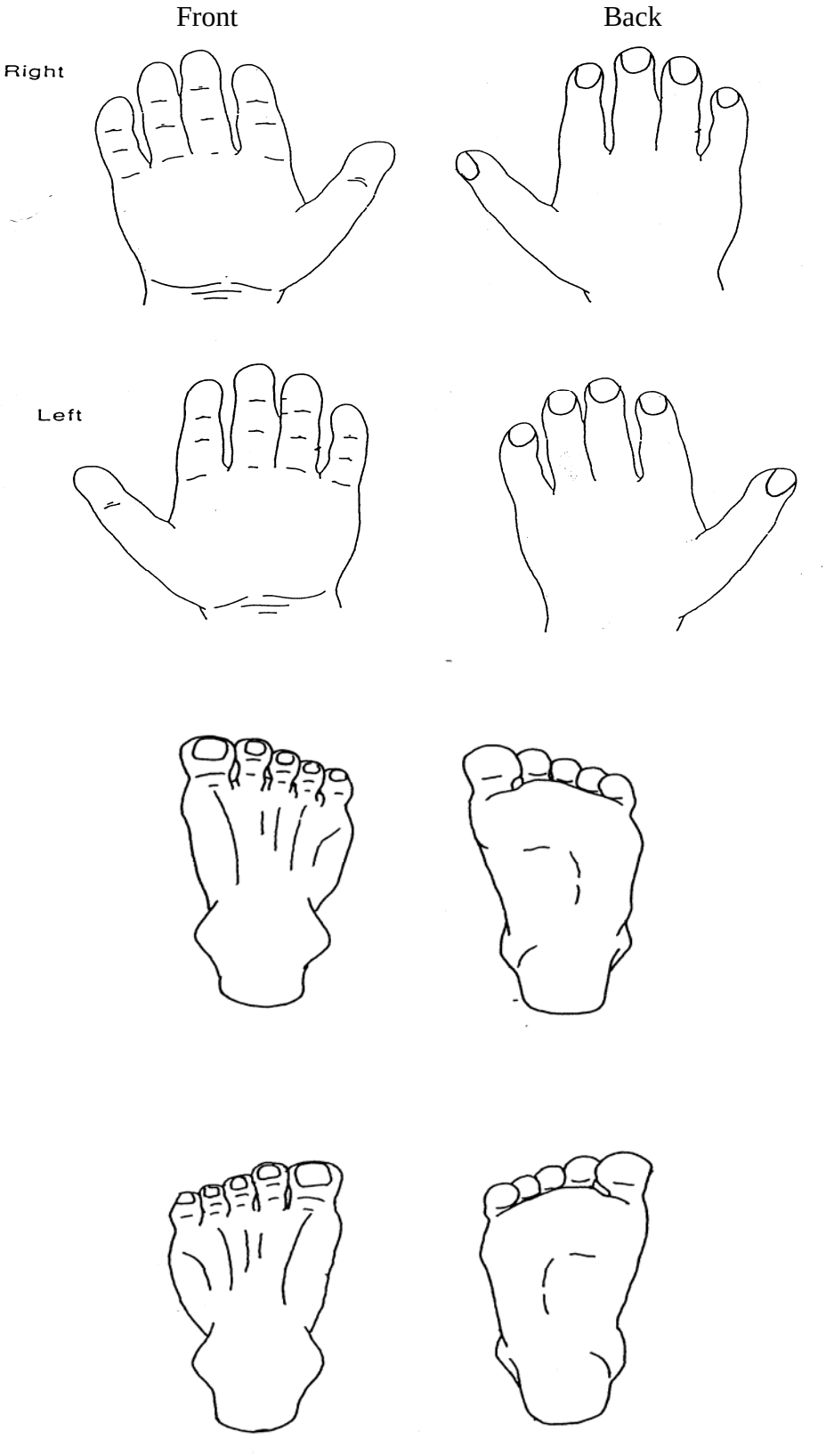
Mark on the diagram below where you have pain or numbness
(Please indicate which is pain and which is numbness).

Front



Back




Front
Back
Right
Left

SENSATION PROBLEMS

- Where do you have numbness?
- How long have you had numbness?
- Describe what makes your numbness worse:
- Describe what makes your numbness better:
- Have you experienced electrical jolts down your spine, arms or legs? Where?

BOWEL/BLADDER PROBLEMS

- Describe any bladder problems:
- How long have your had bladder problems?
- Describe any bowel problems:
- How long have you had bowel problems?

BALANCE

- Describe any problems with your balance:

WEAKNESS

- Describe any weakness in your arms or legs (include examples).
- How long have you had this weakness?
- Have you noticed any change in your dexterity, such as picking up change or buttoning your shirt? If so, please describe:
- Describe what makes your weakness worse.
- Describe what makes your weakness better.

16. Mark your average level of stress in the last month?

At home

Small Amount High Amount
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

At work

Small Amount High Amount
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

17. How well are you able to cope with that stress?

At home

Not at all Very Well
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

At work

Not at all Very Well
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

18. How did the pain that you are now experiencing occur?
   a. Sudden onset with known accident or explanation
   b. Slow progressive onset
   c. Slow progressive onset with which suddenly got worse without an accident or explanation
   d. A sudden onset without an accident or definable event

19. Does movement have any effect on your pain?
   a. The pain is always worsened by use or movement
   b. The pain is sometimes worsened by use and movement
   c. The pain is not altered by use and movement

20. Does weather have any effect on your pain?
   a. The pain is usually worse with damp or cold weather.
   b. The pain is occasionally worse with damp or cold weather.
   c. Damp or cold weather have no effect on the pain.

21. How often do you have trouble falling asleep?
   a. Trouble falling asleep due to pain most nights of the week
   b. Occasionally having difficulty falling asleep due to pain
   c. No trouble falling asleep due to pain
   d. Trouble falling asleep which is not related to pain

22. How often do you awaken from sleep?
a. Never
b. Awakened by pain most nights
c. Occassionally awakened from sleep by pain
d. Restless sleep or early morning awakening with or without being able to return to sleep, both unrelated to pain

23. Has your pain affected your intimate personal relationships?
a. No **b.** Yes

1. Are you presently receiving or have you ever received psychiatric/psychological treatment?
a. No **b.** Presently receiving psychiatric treatment **c.** Previous psychiatric treatment

2. Have you ever thought of suicide?
a. No **b.** Yes **c.** Previous suicide attempts

3. Are you a victim of emotional abuse, physical or sexual abuse?
a. No **b.** Yes **c.** No comment

4. Are you still working?
a. Work every day at the same pre-pain job.
b. Work every day but the job is not the same as the pre-pain job with reduced responsibility or physical activity
c. Work occasionally.
d. Not presently working.

5. Are you able to do your household chores?
a. Do same level of household activities without discomfort.
b. Do same level of household chores with discomfort.
c. Do less of household chores.
d. Most household chores are now performed by others.

INJURY

- If this visit is due to an injury, please describe **in detail** when and how it occurred (Be specific).

If you had three wishes for anything in the world, what would you wish for?

1.

_____

2.

_____

3.

_____