PATIENT DEMOGRAPHIC INFORMATION / DAYTON PAIN CENTER, LLC.

Patient Name: ______________________________ SSN#: _____-_____-______ DOB: _____/_____/19____

Sex: M / F Address: ____________________________________ City: _______________OH Zip: ________

Home Tel #: ____________________ Work Tel #: ____________________ Cell Tel # ____________________

E Mail : ______________________________ Profession: ______________________________

Employer/Address: ______________________________ City: ________________ State: _____ Zip: ________

Marital Status: Single / Married / Widowed Family Doctor: ________________ Tel # __________Fax__________

Spouse's Name: ______________________________ Spouse's SSN#: _____/_____/______

Spouse's Employer: ______________________________ Spouse's Employer Tel #: ____________________

Spouse's Emp. Address: ______________________________ City: ________________ OH Zip: ________

Who may we thank for referring you to us: ______________________________ Tel #: ________________

Referring Physician Name: ______________________________ Tel #: ____________Fax # ____________

Ref Physician Address: ______________________________ City: ________________ OH Zip: ________

Reason for Referral: ____

In case of emergency who may we contact: ______________________________ Tel # ____________

Is this visit due to injury: Yes / No Type of injury: Auto / BWC______________________________

Nearest relative not living with you: ______________________________ Tel # ____________

Nearest friend not living with you: ______________________________ Tel # ____________

Landlord Name: ______________________________Tel # ____________

INSURANCE INFORMATION Financial Responsible party for billing ______________________________

Insurance Name: ____________________ Policy # ________________ Group # ____________ ID # ______

Address: ______________________________ City: ________________ State: _____ Zip: ________

Tel # ____________________Insured Name: ______________________________ SS# ________________

Secondary Insurance: ____________________ Policy # ________________ Group # ____________ ID # ______

Address: ______________________________ City: ________________ State______ Zip ________

Tel # ____________________Insured Name : ______________________________ SS # ________________

Workers Compensation: Company: ______________________________Address: ______________________________

Telephone # ________________ Claim # ____________ Date Of Injury: ____/_____/________Case worker________

AUTHORIZATION: I hereby authorize DAYTON PAIN CENTER, LLC. to release any information concerning my illness and treatments and that of my dependents. I also authorize payment of medical benefits of DPC for services rendered. I understand and agree (regardless of my status) that I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completes all the answers. I CERTIFY this information is true and correct to the best of my knowledge. I will notify any changes in my status or the above information

Responsible party Signature: ____ Date: ________/_______/2018

Patient's Detailed Pain History narrated by the patient

PatientName____**Date**_________/_________/2018

Krishna B. Reddy, MD; S. Erragolla, MD; L. Mathai; J. Gouda, MD; S. Singh, MD., E. Nelson, MD; G. Kluge, MD; S. Mathai,
Dayton Pain Center/Wright Path Recovery

Referring MD: ______________________________ Primary care MD: ________________________________

Circle and use check marks when appropriate. Down loading and proper filling it prior to coming to the office visit will save you waiting time. You will not be seen with out completed forms.

I: **Chief** Complaint(s)**:** Describe in your words where it is? what pain is like, How it feels? **When and how** did your problem first started (accident, injury etc?) Describe each area of pain separately. If BWC, describe the first injury in detail & job title & duty.

1.____
____

2.____
____

3____
____

HPI: Severity of pain level Location: (In a scale of 0 - 10 per body part. 0 being no pain, 10 being worst pain in your life)
Head ______ Face:______ Neck:________Thorax:________ Lumbo-sacral______________________________ Extremities: Upper: R _____ L_____ Lower: R______L________ Chest:_______ Abdomen:_____________ Other_____ Joints: Shoulder:______ Elbow:______ wrist:______ Hip:______ Knee:______ Ankle:________ Other____________________________________

4. Does your pain radiate: Yes to____No
5. How long? Is it constant? Does it come and go?____

6. How many hours you sleep? _______ Do you toss & turn?: Yes / No Does Pain Wakes you Up?: Yes / No
7. Have you seen any other Pain Physician(s)/Chiropractic physician:Yes____________________________No
8: What type of injections you have? Bywhom?____
9. Pain level without medications (0-10): _______ Pain level with medications (0-10): ___________________
10. Using the pain scale of 0-10 Please rate what your acceptable AVERAGE LEVEL of pain would be**?** ______________
11. Sleep disturbance (difficulty falling/staying asleep) Yes / No. If yes duration: ____________________
12. Were you told that you snore while you are sleeping? No / Yes If yes did you have any sleep studies? Yes / No
13. Do you have perception of non-painful stimuli as being painful (Allodynia) Touch of cloths/bed sheets cause pain Yes / No
Character (quality) **of pain:**: **Nociceptive**: Dull ache, cramping, waxing, waning, sharp, tender.______________________
Neuropathic: Burning, stabbing, lancinating, Pricking, fan causing pain, tingling/numbness, shooting, pins/needles,
Which Movement is more painful? Is it Bending **Backwards**? Yes / No Is it Bending **forwards**? Yes / No Altered feeling (hot, cold, freezing, itching, Burning, Bugs crawling, Electric shock in Upper / Lower / extremities.
Do you have **muscle Spasms**? Yes / No How often? Frequently / Rarely / During night / None
Modifying Factors:
Pain aggravated by prolonged sitting, standing walking, bending squatting, climbing, lifting, pulling, pushing, and carrying ____
Pain relieved by rest, lying down, hot shower, heating pad, medications, exercise, TENS, bio-feed back, physical therapy ____
Functional Ability in relation to pain and comfort on a daily basis without pain medications: Non functional Poor Fair

How is your ability to manage your relationship with others: ____
What is your ability to do daily activities or job: ____
Past treatments for the present problem **(When, where, who performed & their efficacy):**

PatientName____Date_________/_________/**2018**

Previous Treatments	Yes	No	Helpful	Not helpful
Physical Therapy Tried?				
TENS Unit Tried?				
Tried Weight loss?				
Pain Blocks Tried?				
Exercise program tried?				
Counseling/Biofeed/Prolo				

H/O NSAIDS (Naprosyn, Ibuprofin etc) usage & the reasons for their failure (side effects, Erosive Gastritis, GERD, Bleeding, cannot tolerate Vioxx, Celebrex, None of them are effective, They are effective one time but not any more______________________

Are you taking any Anxiety & Depression Medications?: Xanx / Ativan / Klonipin / effexor / Lexapro / abilify / seroquil / celexa / prozac / Paxil ____

Medication History other than pain Medications for the last 3 years: ____
____
____
____

Which Pain Medications **has helped:** ____

Which Pain medications **has not helped**: ____

Are you on any **Blood Thinners?** Aspirin, Advil, Plavix, coumadin, NSAIDS, Tyclid, Zarolto________________________________

Side effects of current or recent medication: None / Constipation / Nausea / Dry mouth / sweating________________________

Medication Allergies: Cannot tolerate NSAIDS / Tylenol with codine / Morphine / Oxycodone / Ultram / Norco / MS Contin_
____

Have you used? (Circle) Neurontin, Topomax, Lyrica, Elavil, Trazadone, lidoderm, dilantin, tegretol, Flector patches_____________
____

Which helped the most**:** ____

Quality of family life, Activities of daily living & social life improved with medications **Yes / No**

Functional with medication: Working, Not working but functional, Functional with some limitation, Not functional **Yes / No**

Are you discharged by your providers? If so why?: ____No

III: **Review of Systems**: (Symptoms related to each system and how long)

Head aches, Duration Does it last longer than 4hrs Y / N Is the Head ache Moderate to Severe Y / N

Do you stay in dark room (Photophobia) Y / N Is your Head ache aggravated by physical activity Y / N

Do you suffer from Head-ache 15 days in a month, lasting more than four hours a day for longer than 3 months Y / N

Aura: Present / Not Present / Associated with Nausea / Need to stay in dark room / Morning / Evening

Anxiety & Depression & Duration (State how these effected by pain) ____

Have you been seen by a **psychiatrist / Psychologist** No / Yes by Dr ____

Do you have any suicide thoughts or ideas: No / Yes ____

Eyes: **Normal**/ Dry eyes/_________ ENT: **Normal/**Dry Mouth____

Lungs: **Normal** Smokers Cough / COPD / Bronchitis / Asthma / Shortness of breath / Sjogren's / Sarcoid / Cancer

Heart: **Normal** Dizziness with standing / Heart attack / Angina / Rapid Heart beat / Irregular heart beat / stints

Gastro Intestinal: **Normal**, Large Bowel, Ulcer, Bypass, Reflux Disease, Colitis, Irritable Bowel, Constipation, crohns, Pancreatitis

Kidney & bladder: Normal, Bladder incontinence, Stones, Cystitis, Prostate, PSA, _______________________________

Endocrine: Normal / Diabetes / Hypothyroid: Use Medicines by mouth / Insulin / Sexual dysfunction ______________________

Blood / clotting / Lymphatic / Anemia, sickle cell, **Normal**____

Infectious Diseases: **Normal** / HIV / Hepatitis B / Hepatitis C / Herpes / cancer__________________________________

Neurologic: **Normal**, Neuropathy / Seizures / Parkinsons / Restless leg / Dizzy / Falls / Fainting / MS____________________

Psychiatric: **Normal**, Depression / Anxiety Neurosis / Panic disorder Bipolar / Personality Disorder ___________________

Musculoskeletel: **Normal**, Fibromyalgia / Spasms / Morning Stiffness / Arthritis / Lupus / Osteoporosis / Gout _________

Cancer: **None**, Liver / Ovary / Lung / intestine / Bladder / Brain / Breast / Prostate / Lymphoma / Hodgkins ____________

Do you have: Low Blood Pressure / Too Much or Too little Sweating / red or white skin discoloration / Dizziness / Balance problems / Burning pain / Sensitivity of skin / Heat or cold intolerance / tremor / ___________________________________

PatientName____ Date__________/_________/2018

IV: Past Medical/Surgical, Test done in the past 1 year for the present problem and their duration

Disease (Circle) Year Diagnosed Medications used for treatment

Disease	
Diabetes / Cancer / COPD / Hepatitis C / Seizures / Thyroid / B12 / HIV / AF	
↑ Blood pressure / Heart Problems	
Syncope / falls / Chemo / Radiation	
Ulcer disease / Gastric Reflux /Hiatal Hernia	
Arthritis: Back Neck Knee Ankle Hip Shoulder	

List any surgeries? Did surgery help? Indicate by **YES or NO** (Circle)

Type of surgery & Hospital name & Doctors name	Helped	Approximate Month/Year
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	

Which of the following tests you had in the past year? (If you have any reports please bring)

Name of the test	Approximate Date	Result of the Test as you understand
X-Rays		
CT / MRI scan(Where & When		
EMG Report		
Consultations(Neurosurgery, Neurology)		
Brain Bone EKG scan		

What imaging studies you have, where & when to help us diagnose your condition? ______________________________________
____
____

Family History: (paternal/maternal/siblings): Neuropathy / Diabetes / Back problems / Cancer / Drug related ________________
Children (ages)(Supporting / Not supporting):____
Sexual dysfunction Yes Secondary to / physical / psychological / medications / Diabetes ________________________No
If yes decrease / loss of desire / delay / unable to achieve orgasm / Loss of potency / unable to sustain erection / __________
Social History: Single / Married / Divorced / Widowed / Living with ____
Current/ Past Work: Working Full time / Part **time / Retired / Disabled / Looking for Last worked:______/______/______**
Job responsibilities (Detailed) (Repetitive using wrist, shoulders, back, heavy lifting, typing, mental, pressure, crawling, bending etc____
Work place Ergo metrics (Circle): Drive Long distance to work / Repetitive tasks / Twisting & lifting / Long sitting / Key Board **/** Not working / Home maker / Sedentary / Function with some limitations / Not functioning _______________
Education: GED / College ____
Smoking: Yes / No If yes Packs per day _____Do you wish to Quit smoking ? Yes / No Quit_______________________
Alcohol use: No / Yes; If yes social / moderate / Used for _______years Quit when ______________________________
Past street drug: Use / dependency / abuse: No / Yes ____
If yes since when/What/How long/Last time used ____
A: Family History of Substance abuse: No / Yes B: Preadolescence sexual Abuse: physical / domestic abuse / Sexual: No / Yes
C: Have you ever tried to cut down on your alcohol or drug use? Yes / No A: Do you get annoyed when commented about drinking or using drugs? Yes / No G: Do you feel guilty about things you have done while drinking or using drugs? Yes / No
E: Do you need an eye-opener to get started in the morning? Yes / No

PatientName____Date__________/_________/2018
Have you had any fractures or dislocations of your bones or joints (excluding sports injuries)? Yes / No
Have you been injured in a traffic accident? Yes / No Have injured your head (Excluding sports injuries) Yes / No
Are you in fight or been assaulted while intoxicated Yes / No Have you been injured while intoxicated Yes / No
Compensation: No / Yes what type BWC -Self Insured / state / federal; social security: SSI / SSD____________________________
If any pain related to injury at work / personal injury: **No** / **Yes** ____
If yes; who was the employer / responsible party at the time of injury ____
Do you have more than one claim **No** / **Yes** Claim # ____
Do you use any **assist devise** (Circle if applicable): No / Cane / Walker / Crutch / Wheel chair / Scooter ______________
Does your pain interfere with your ability to Carry Groceries / Climb stairs / bathe / dress / ability to use bath room / personal grooming
How would you rate your overall **energy?** (0-10) : _____ How would you rate your strength & endurance? (0/10 scale): ___
How would you rate your feeling of depression (0-10 scale): _____ How would you rate your feelings of **anxiet**y (0-10) : ___
How would you rate your strength, endurance, energy and overall physical activity (0-10 scale) : ___

Where can we get your Medical records. Provide names, phone & Fax numbers (MRI, X-rays notes etc): __________________
____
____

Pharmacy Information: I will use only one pharmacy (Required) Name: ____
Address :____ Tel #____
I listed all my medications in the **pain contract** form. The above information, I provided is accurate to the best of my knowledge.

Signature of the patient.:____Date: ________/_______/2018

Available data reviewed include:

1) Medical records from prior physicians reviewed include MRI Medications Progress notes Operative report X-rays Pharmacy bottles
2) UDS: Done Reviewed waiting for confirmation____
3) OAARS Report: Reviewed Single / group / Multiple Prescribers____
4)____

___________________________________ _____________________________ Date: ________/_______/2018

Reviewed, Assisted & **Signed by Assistant** Reviewed, corrected & Signed by Physician

Drs. B. Reddy, S. Erragolla, L. Mathai , J. Gouda, S. Singh, E. Nelson, G. Kluge

Krishna B. Reddy , MD.; S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; S. Singh, MD., E. Nelson, G. Kluge, S. Mathai, MD.,
Dayton Pain Center/Wright Path Recovery

Screener and Opioid Assessment of Patients with Pain-Revised (SOAPP-R)

PatientName____**Date**_________/________/2018

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. **There are no right or wrong answers**.

	Never	Seldom	Some times	Often	Very Often
	0	1	2	3	4
1. How often you have mood swings?	0	1	2	3	4
2. How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
3. How often have you felt impatient with your doctors?	0	1	2	3	4
4. How often have you felt that things are just too overwhelming that you can't handle them?	0	1	2	3	4
5. How often is there tension in the home?	0	1	2	3	4
6. How often have you counted pain pills to see how many are remaining?	0	1	2	3	4
7. How often have you been concerned that people will judge you for taking pain medication?	0	1	2	3	4
8. How often do you feel bored?	0	1	2	3	4
9. How often have you taken more pain medication that you were supposed to?	0	1	2	3	4
10. How often have you worried about being left alone?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have others expressed concern over your use of medication?	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
14. How often have others told you that you had a problem with alcohol or drugs?	0	1	2	3	4
15. How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
16. How often have you run out of pain medication?	0	1	2	3	4
17. How often have others kept you from getting what you deserve?	0	1	2	3	4
18. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
19. How often have you attended an AA or NA meeting?	0	1	2	3	4
20. How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
21. How often have you been sexually abused?	0	1	2	3	4
22. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
23. How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
24. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
Total of Each Column (Add the marked numbers in each Column)					
Total of the last four columns					

SOAPP-R Low Score < 9 Moderate R Score 10-21 Moderate R Score > 22 High R 18 or over is Positive Below 18 Negative

______________________________ ______________________________

Patient's Signature MD/Counselor/PA/CNP Signature

Krishna B. Reddy , MD.; S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; S. Singh, MD., E. Nelson, G. Kluge, S. Mathai, MD.,
Dayton Pain Center/Wright Path Recovery

Patient Name: ____ _____________ Date: __________/__________/2018

SBQ-R Suicide Behaviors Questionnaire-Revised

Instructions: Please check the number beside the statement or phrase that best applies to you

1. **Have you ever thought about or attempted to kill yourself ? Check one only**
   - □ 1. Never
   - □ 2. It was just a brief passing thought
   - □ 3a. I have had a plan at least once to kill myself but did not try to do it
   - □ 3b. I have had a plan at least once to kill myself and really wanted to die.
   - □ 4a. I have attempted to kill myself, but did not want to die
   - □ 4b. I have attempted to kill myself, and really hoped to die

2. **How often have you thought about killing yourself in the past year?**
   - □ 1. Never
   - □ 2. Rarely (1 time)
   - □ 3. Sometimes (2times)
   - □ 4. Often (3-4times)
   - □ 5. Very often (5 05 more times)

3. **Have you ever told someone that you were going to commit suicide, or that you might, do it?**

   - □ 1. No
   - □ 2a. Yes, at one time, but did not really want to die
   - □ 2b. Yes, at one time, and really wanted to die
   - □ 3a. Yes, more than once, but did not want to do it
   - □ 3b. Yes, more often than once, and really wanted to do it

4. **How likely is it that you will attempt suicide someday?**
   - □ 0. Never
   - □ 1. No chance at all
   - □ 2. Rather unlikely
   - □ 3. Unlikely
   - □ 4. Likely
   - □ 5. Rather likely
   - □ 6. Very likely

Total Score: ________________ Score of 7 or More ________________

Clients Statement: I am_____________________________________ hereby assuring the Dayton Pain Center staff that while I am under the influence the drug use, had the suicidal thoughts. I would like to assure the staff at Dayton Pain Center that I would seek help from my sponsor, counselor and physicians for any suicidal thoughts or ideation. I will seek hospital admission if I have thoughts of suicidality any longer than few hours

____ ____

Patient's Signature MD/Counselor/PA/ CNP Signature

Krishna B. Reddy , MD.; S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; S. Singh, MD., E. Nelson, G. Kluge, S. Mathai, MD.,
Dayton Pain Center/Wright Path Recovery

Becks Anxiety Inventory (BAI)

Patients Name: ______________________________ **Date:** _____/_____/2018

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TO DAY. by circling the number in the corresponding space in the column next to each symptom.

	Not At All	**Mildly It did not bother me much**	**Moderately it was very unpleasant but I could stand it**	**Severely I could barely stand it**
1. Numbness or tingling	0	1	2	3
2. Feeling Hot	0	1	2	3
3. Wobbliness of Legs	0	1	2	3
4. Unable to relax	0	1	2	3
5. Fear of the worst happening	0	1	2	3
6. Dizzy or lightheaded	0	1	2	3
7. Heart pounding or racing	0	1	2	3
8. Unsteady	0	1	2	3
9. Terrified	0	1	2	3
10. Nervous	0	1	2	3
11. Feeling pf chocking.	0	1	2	3
12. Hands trembling	0	1	2	3
13. Shaky	0	1	2	3
14. Fear of losing control	0	1	2	3
15. Difficulty breathing	0	1	2	3
16. Fear of Dying	0	1	2	3
17. Scared	0	1	2	3
18. Indigestion or discomfort in abdomen	0	1	2	3
19. Faint	0	1	2	3
20. Face Flushed	0	1	2	3
21. Sweating (Not due to heat)	0	1	2	3
Total of each Column	0			
Total of the last three columns				

Low Anxiety: 1-21 Moderate Anxiety: 22-35 High Anxiety: 36 or above

______________________________ Patient Signature

______________________________ MD/Counselor/PA/CNP Signature

Krishna B. Reddy , MD.; S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; S. Singh, MD., E. Nelson, G. Kluge, S. Mathai, MD.,
Dayton Pain Center/Wright Path Recovery

Patient Health Questionnaire (PHQ-9) (Depression)

Patients Name: ________________________________ **Date:** ______/______/2018

Over the last 2 weeks how often you have been bothered by any of the following problems?	Not at all (0)	Several Days(1)	More than half the days (2)	Nearly Every Day(3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling / staying asleep, sleep too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching the television	0	1	2	3
8. Moving or speaking so slowly that other people could have notified. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
	Not difficult at all	Some what difficult	Very difficult	Extremely difficult
10. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	0	1	2e	3
Total Score Each Column	0			
Total of All Columns				

Mild: 5-9 Moderate: 10-14(Support) Moderately Sever: 15-19 (Antidepressant or Psychotherapy) Severe: 20 + (Antidepressant + Psychotherapy

______________________________ ______________________________

Patient Signature MD/Counselor/PA/CNP Signature

Krishna B. Reddy , MD.; S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; S. Singh, MD., E. Nelson, G. Kluge, S. Mathai, MD.,
Dayton Pain Center/Wright Path Recovery

Psychological Evaluation

Patients Name: ____ **Date:** ________/________/**2018**

The assessment of psychological influences is an important part of the initial evaluation of patients with chronic pain. The goal of pain assessment is to determine the contribution of affective, cognitive, and behavioral factors to the perception and report of pain. This helps in the formulation of reasonable treatment goals.
Some of the psychological symptoms observed are secondary to the pain complaint, while others may have been in existence before pain occurred. Regardless of the chronological order, patients' response to the pain treatment is likely to be affected if the psychological factors are not identified and treated.
Depression and anxiety are two of the most important disorders to assess in chronic pain patients. Depression creates rehabilitation failure by causing low motivation, poor morale, low energy and hopelessness. Highly anxious patients become incapacitated with fear and embarrassment.

Chief complaint: Chronic pain in back, Neck, extremities, Head; Other ______________________________

Dx: codes____

Patent complains of:

- No psychological issue
- Feeling depressed, and /or anxious
- Sleep disturbances,
- Past h/o treatment for mental health,
- Suicidal thoughts.
- Other:

Current medications: ____

Beck Depression Inventory and Beck's Anxiety Inventory administered

PHQ-9 Score _______ Low (5-9), Moderate (10-19), Severe (20 +)
BAI Score _______ Low (0-21), Moderate (22-35), Severe (36-63)

Assessment: ____

Treatment plan:

- Test scores reviewed with patient
- Counseled regarding chronic pain management and adherence to treatment plan
- Referred to Psychiatrist / Psychologist / Counselor
- Reevaluate at a later date as needed.

____

Drs. B K Reddy, L Mathai, Dr. Erragolla, J. Gouda, S. Singh, E. Nelson, G. Kluge

Krishna B. Reddy , MD.; S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; MD; S. Singh, MD., E. Nelson, G. Kluge, S. Mathai, MD.,
Dayton Pain Center/Wright Path Recovery

Criteria for AFT QSATRT & Skin Biopsy

Patients Name: ______________________________ **Date:** ______/______/**2018**

Please Circle the following symptoms & conditions if you are experiencing them. Circle things apply to you.

1	Do you have Constipation or Diarrhea?	Yes	No
2	Are you Feeling full after only few bites / Nausea after eating / Swollen Abdomen?	Yes	No
3	Do you have Unintentional loss of more than 5% of body weight?	Yes	No
4	Have you vomited the Undigested food?	Yes	No
5	Do you have Blood pressure changes with position changes Lying down to standing, sitting to standing?	Yes	No
6	Do you Feel like incompletely emptying the bladder?	Yes	No
7	Do you have Urinary Incontinence (Lower flow incontinence)?	Yes	No
8	Do you have Abnormal sweating (Too much sweating or too little sweating)?	Yes	No
9	Do you Feel like fainting, dizzy, unsteady, when walking, has fallen with balance problems?	Yes	No
10	Do you have Heat Intolerance?	Yes	No
11	Do you have Male Impotency?	Yes	No
12	History of rapid heart rate or abnormally slow Heart rate?	Yes	No
13	Difficulty Swallowing?	Yes	No
14	Do you have lightheadedness or dizziness, palpitations, pre-syncope and sense of weakness?	Yes	No
15	Do you suffer from Diabetes, Fibromyalgia, Amyloidosis, or Sarcoidosis?	Yes	No
16	Are you taking Insulin and or oral anti-diabetic medications?	Yes	No
17	Do you have blackouts and seizures, Unsteady when walking & climbing. Has stroke affecting balance?	Yes	No
18	Do you suffer from burning pain, tingling or numbness with excessive sweating?	Yes	No
19	Does the fan blow air cause increase in your pain over your feet and hands?	Yes	No
20	Do you have the feeling of bugs crawling on your hands and feet?	Yes	No
21	Does your feet and hands turn purple when you stand or weather changes?	Yes	No
22	How much alcohol do you consume?	Yes	No
23	Do you suffer from Parkinson's disease, multiple sclerosis, HIV, AIDS, and alcoholic neuropathy/	Yes	No
24	Do you suffer from Diabetic Neuropath, Sjogrens syndrome, Systemic Lupus or post Herpetic Neuropathy?	Yes	No
25	Are you on hypotensive, anti psychotics, hypnotics, anxiolytics, antiarrhythmics and anti-parkinson Medications?	Yes	No
26	Are you diagnosed with any cancer? Did you receive any chemotherapy and or radiation?	Yes	No
27	Were you diagnosed with Hypothyroidism, Premature Menopausal symptoms and or Guillain Barre syndrome?	Yes	No
28	Did you undergo Gastric by Pass Surgery?	Yes	No
29	Did you have Gastric bypass Surgery or Banding?	Yes	No
30	Do you suffer from Sleep Apnea, Sleep disorders, Asthma and or COPD	Yes	No
31	Do you suffer from Depression, Anxiety, Panic disorder, PTSD, Attention Deficit Disorder?	Yes	No
32	Were you diagnosed with peripheral Neuropathy?	Yes	No
33	Do you use cane, walker, wheel chair or any assistive devise?	Yes	No

______________________ ______________________________________

Patient's Signature Drs. Reddy, Erragolla, Mathai, Gouda, Singh, Nelson, Kluge