American Health Network
Spinal Therapeutics and Diagnostics

3570 Briarwood Ln.
Muncie, IN 47304
Tel: 1-765-213-6373
Fax: 1-765-213-6373

Neal E. Coleman, MD and Andrew Trobridge, MD
Amy Padgett, ANP

Patient name: ____

Appointment date: ____

Appointment time: ____

Welcome to American Health Network Spinal Therapeutics and Diagnostics.

Please fill out all the forms in this packet. Bring the completed packet with you to your visit. This information is important for our doctors to give you proper care. It'll also help remind you of the time and date of your appointment.

As this is your first visit, please arrive 30 minutes before your appointment. That'll give us time to get any more information we may need.

We have a small waiting area. We ask that only the patient and one caregiver come to the appointment. If you have to bring your children with you, you'll need to bring another adult who can watch your children while you're at your appointment.

Please plan on your first visit taking two hours. The doctor will look at your health records, give you an exam, and see what test(s) you may need. **It's very unlikely that your doctor will prescribe any medicines on your first visit.** This is due to all the issues with prescription drugs today.

When you come in, please bring a list of any medicines you're taking. You'll need to show your insurance card(s) driver's license or photo ID. Without proper ID, we won't be able to see you. We'll have to reschedule your appointment.

If you have a copay, you'll need to pay it at check-in. **Also, please check with your health insurance plan to make sure your visit is covered.**

If you can't keep your appointment, please tell us at least 24 hours before your appointment. Please note we have a "no-show" policy. If you miss an appointment or give less than 24 hours' notice, you may need to pay a "no-show" fee. If you're late, we may have to be reschedule your appointment.

Questions?
Please call our office at 1-765-213-6373. Our office can be reached Monday through Thursday from 8 a.m. to 4:30 p.m.

Sincerely,

The doctors and staff of American Health Network Spinal Therapeutics and Diagnostics

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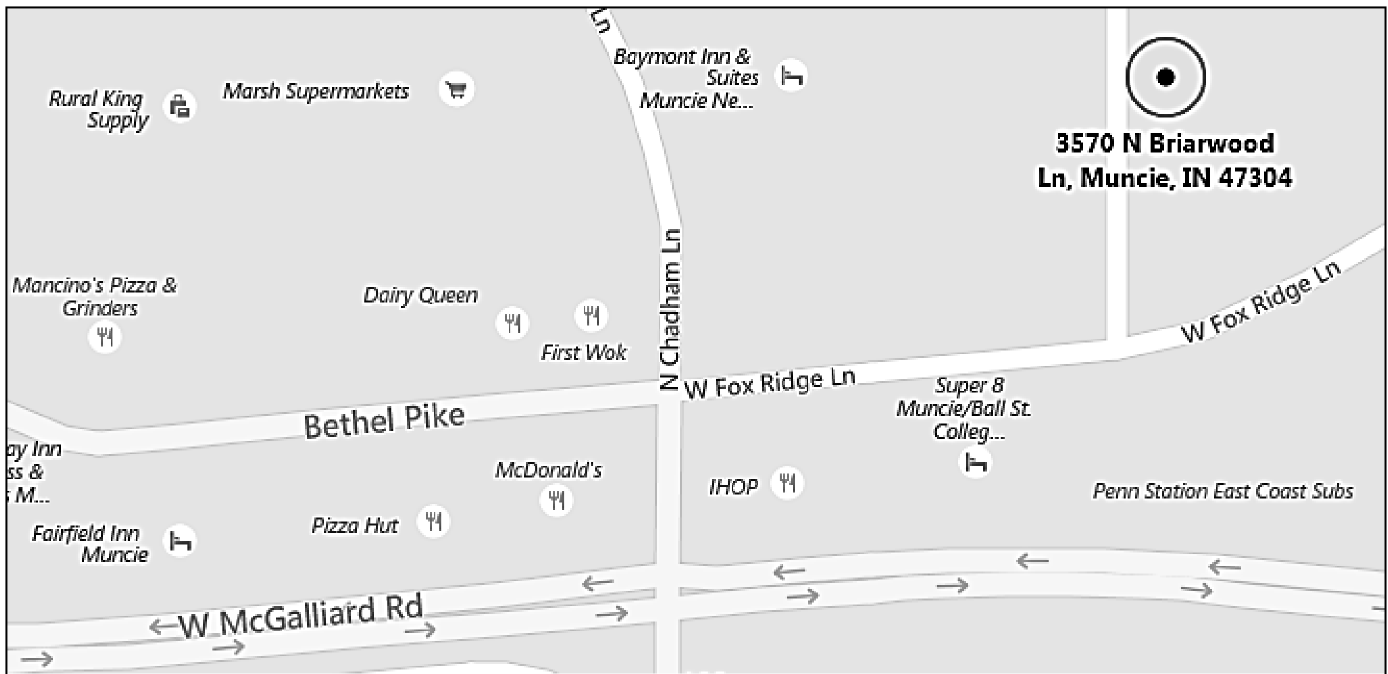

Directions

Directions from I-69:

- Take the exit for IN-332 and head east.
- IN-332 becomes W McGalliard Rd. as you head toward Muncie.
- Go left (north) at the intersection of W McGalliard Rd. and N Chadam Ln.
- Take the next right on W Fox Ridge Ln.
- Turn left at N Briarwood Ln.
- Our office is on the right side of the street, across from Lyndenbrook Falls Miniature Golf.
- Look for the American Health Network sign on the front of our office.

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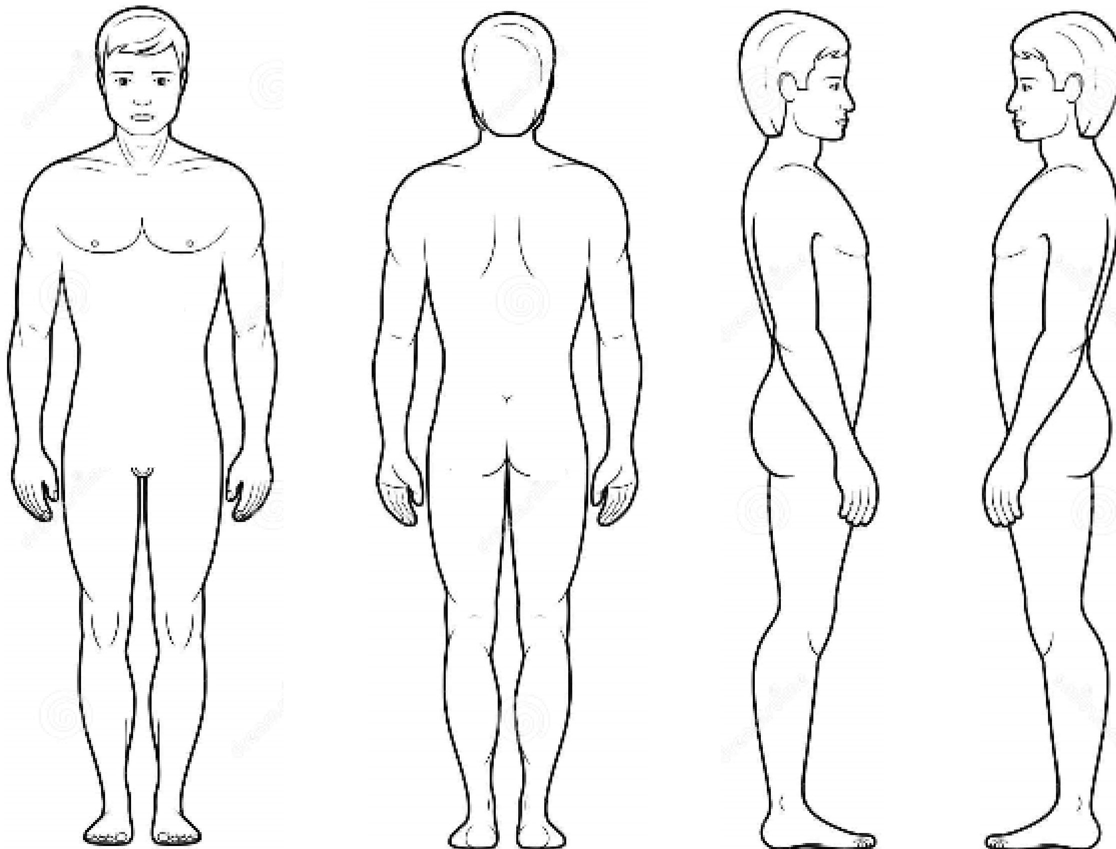
Please shade in the areas where you have pain.
If your pain travels, please show where on the body.

Today's date: ____________________________

Name: ____

Date of birth: _________________________



American Health Network
Spinal Therapeutics and Diagnostics
Oswestry Disability Index

Patient name:____

Date of birth:_______ Date:_____________

Please mark only **one** (1) box per section, based on how you feel today.

Section 1: Pain level	Section 6: Standing
☐ I have no pain at the moment. ☐ The pain is light at the moment. ☐ The pain is medium at the moment. ☐ The pain is fairly high at the moment. ☐ The pain is very high at the moment. ☐ The pain is the almost unbearable at the moment.	☐ I can stand as long as I want without extra pain. ☐ I can stand as long as I want but it causes extra pain. ☐ Pain prevents me from standing for more than 1 hour. ☐ Pain prevents me from standing for more than ½ hour. ☐ Pain prevents me from standing for more than 10 minutes. ☐ Pain prevents me from standing at all.
Section 2: Personal care (washing, dressing, etc.)	**Section 7: Sleeping**
☐ I can look after myself without causing extra pain. ☐ I can look after myself but it causes extra pain. ☐ It's painful to look after myself and I'm slow and careful. ☐ I need some help but I can do most of my self-care. ☐ I need help every day in most aspects of self-care. ☐ I don't get dressed, wash with difficulty, and stay in bed.	☐ My sleep is never disturbed by pain. ☐ My sleep is sometimes disturbed by pain. ☐ Because of pain, I get less than 6 hours of sleep. ☐ Because of pain, I get less than 4 hours of sleep. ☐ Because of pain, I get less than 2 hours of sleep. ☐ Pain prevents me from sleeping at all.
Section 3: Lifting	**Section 8: Sex life**
☐ I can lift heavy weights without extra pain. ☐ I can lift heavy weights but it causes extra pain. ☐ Pain prevents me from lifting heavy weights but I can lift things that are easy to get to (like a table). ☐ Pain prevents me from lifting heavy weights but I can lift light to medium weights if they're easy to get to. ☐ I can only lift very light weights. ☐ I can't lift or carry anything.	☐ Not Applicable. ☐ My sex life is normal and doesn't cause extra pain. ☐ My sex life is normal but causes extra pain. ☐ My sex life is nearly normal, but is painful. ☐ My sex life is somewhat limited by pain. ☐ My sex life is very limited because of pain. ☐ Pain prevents any sex life at all.
Section 4: Walking	**Section 9: Social life**
☐ Pain doesn't prevent me from walking any distance. ☐ Pain prevents me walking more than 1 mile. ☐ Pain prevents me walking more than ½ mile. ☐ Pain prevents me walking less than a ½ mile. ☐ I can only walk using a cane or crutches. ☐ I'm in bed most of the time.	☐ My social life is normal and gives me no extra pain. ☐ My social life is normal but increases my pain. ☐ Pain has no real effect on my social life other than limiting more energetic activities (like sports, etc.). ☐ Pain has limited my social life and I don't go out as often. ☐ Pain has limited my social life to home. ☐ I have no social life because of pain.
Section 5: Sitting	**Section 10: Traveling**
☐ I can sit in any chair as long as I like. ☐ I can only sit in my favorite chair as long as I like. ☐ Pain prevents me from sitting for more than 1 hour. ☐ Pain prevents me from sitting more than ½ hour. ☐ Pain prevents me from sitting more than 10 minutes. ☐ Pain prevents me from sitting at all.	☐ I can travel anywhere without pain. ☐ I can travel anywhere but it causes me extra pain. ☐ Pain is bad, but I can handle journeys over 2 hours. ☐ Pain limits me to journeys of less than 1 hour. ☐ Pain limits me to short, necessary trips under 30 minutes. ☐ Pain prevents me from traveling anywhere except to get care.

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Patient health history form

Patient Name:________________________________ Date of Birth:__________________

Why are you here? ____

Who Sent you to us?____

When did your pain start?____________________________________

Is it a result of an accident? ☐ Yes ☐ No If yes, date of accident: ____________________

Please describe the accident: ________________________

____

____

If you need more space to tell us about the accident, please use an extra sheet of paper. If you type the details on a computer, please bring a printed copy.

Tell us about your pain:____

Where do you hurt? ____

Please rate your pain, from 0 being no pain to 10 being the worst pain you can imagine, please circle:

How bad your is your pain right now: 0 1 2 3 4 5 6 7 8 9 10

What's the least pain you've had in the last month: 0 1 2 3 4 5 6 7 8 9 10

What's the worst pain you've had in the last month: 0 1 2 3 4 5 6 7 8 9 10

What words describe your pain? (Circle all that apply):

Sharp Shooting Dull Achy Burning Boring

What have other doctors told you the problem is?

1.____

2.____

3.____

4.____

What tests have you had for this problem? Please list when and where the tests were done:

- ☐ X-ray: ____
- ☐ EMG: ____
- ☐ MRI: ____
- ☐ Blood tests: ____________________________________
- ☐ Psychological testing: ____________________________

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Patient name:____Date of birth:__________________________

What treatment(s) have you had for this problem?

____

____

____

Please list all medicines you're taking now:

Medicine	Strength	How often?	Who prescribed?

Have you tried alternative therapies for this problem?

Physical therapy?	Yes	No
TENS or other skin surface electrical?	Yes	No
Chiropractic?	Yes	No
VAXD?	Yes	No
Injections?	Yes	No

Have you had surgery? If so, please describe.

Surgery	Surgeon	Date	Hospital

Do you have other health issues (such as high blood pressure, diabetes, thyroid issues or heart problems, etc.)? If so, please list them.

____

____

____

____

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Patient name:______________________________ Date of birth: ____________________

What other treatments have you had? What was the treatment for and did it help?

____

____

____

Do you live with anyone now? Please list:

____

____

Are your parents living?____

Have your parents had a pain condition? If so, please describe:

____

____

Do any of your relatives have a long-term pain condition? If so, please list who and their condition:

____

____

____

Do any of your relatives have a drug or alcohol problem?	Yes	No
Do you smoke tobacco?	Yes	No
Do you drink alcohol?	Yes	No

Work:

What industry do you work in? ____

Who's your employer? ____

What kind of tasks do you do: ____

Body systems (please check all that apply and fill in the blanks).

General

___ Fever

___ Chills

___ Tiredness

___Trouble sleeping. Hours of sleep per night?__

___ Dizziness

___ Forgetfulness

___ Weight loss. How much? _____

___ Weight gain. How much? _____

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Patient name:____**Date of birth:** ____________________

Nervous system

___ Headache ___Pain in legs ___Pain in arms

If so, what part of your head? ____

How often? ____

How long do they last? ____

What treatments work? ____

What treatments don't work? ____

Breathing

___ Sleep apnea ___Voice change ___Sore throat ___Wheezing

___ Cough ___Stuffy nose ___Short of breath in cold ___Runny nose

___ Short of breath when walking up stairs

___ Do you smoke? If so, what and how much? ____________________

Heart

___ Chest pain or tightness ___Rapid heartbeat ___Short of breath when walking a block

___ Fainting or passing out ___Have to sleep with your head up ___Short of breath when lying down

___ Heart cath or surgery ___Wake up at night short of breath

Blood flow

___ Pain in legs when walking ___Frostbite ___Blood clots

___ Fingers or toes turn blue or black ___Raynaud's disease (numbness)

Stomach and digestion

___ Weight loss ___Stomach pain ___Feeling sick ___Vomiting blood

___ Dark, coffee-ground-like bowel movement ___Blood from rectum___Diarrhea

___ Constipation: How often do you usually have bowel movement? Every_____days.

___ Incontinence of stool

When was your last rectal and colon exam? ____

Do you drink alcohol? If yes, what and how much:____

Lymphatic

___ Swollen glands

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Muscles and joints

___ Painful knots in muscles ___Feeling stiff in the morning

___Swollen joints. If so, which ones?____

Urinary

___ Trouble urinating ___ Bladder exam ___ Leaking urine when you cough or strain

___ Bladder test ___ Blood in urine ___ History of incontinence

___ Trouble with bladder control ___ Pain urinating ___ Flank pain (between ribs and groin)

___ Wake nightly to pee. If so, how many times a night? _____________

Male reproduction

___ Unable to have an erection ___Unable to ejaculate

Female reproduction

Date of last menstrual cycle? ________ Is it possible you are pregnant? ___Yes ___No

___ Pain around your reproductive organs

Skin

___ Rash ___ Sores that won't heal ___Bruise easily ___Tears easily

Immune system

___ Frequent infections. If so, where?____

___Exposed to HIV

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In the last 14 days, how often have you had the following problems?

(0= not at all; 1= a few days; 2= more than seven days; 3= nearly every day.)

1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed, hopeless:	0	1	2	3

		Mark each box that applies	Item score if female	Item score if male
1.) Family history of substance abuse?	Alcohol	[ ]	1	3
	Illegal drugs	[ ]	2	3
	Prescription drugs	[ ]	4	4
2.) Personal history of substance abuse?	Alcohol	[ ]	3	3
	Illegal drugs	[ ]	4	4
	Prescription drugs	[ ]	5	5
3.) Mark box if you're age 16–45		[ ]	1	1
4.) Victim of childhood sexual abuse?		[ ]	3	0
5.) Mental illness?	Attention deficit hyperactivity disorder (ADHD)	[ ]	2	2
	Obsessive-compulsive disorder (OCD)	[ ]	2	2
	Bipolar disorder	[ ]	2	2
	Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		Total:	_____	_____

What's your overall risk?

Low risk: 0–3
Medium risk: 4–7
High risk: 8 or higher