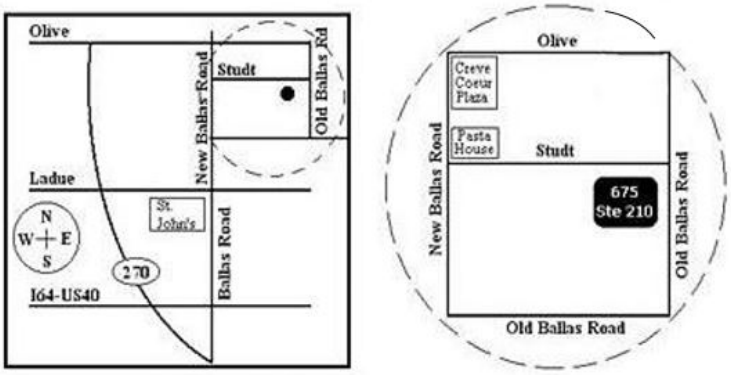
PERFORMANCE
REHABILITATION
& REGENERATION

IV NUTRIENTS • STEM CELLS/PRP • NERVE STUDIES

WE ARE LOCATED AT THE CORNER OF OLD BALLAS & STUDT RD



675 Old Ballas Road, Suite 210
St. Louis, MO 63141

PLEASE CHECK OUT OUR WEBSITE AT
WWW.RAVIYADAVA.COM FOR A MORE DETAILED MAP

Please fill out your form in its entirety prior to arriving for your appointment. All questions are designed to help Dr. Yadava serve you optimally. Please limit your answers to the choices given. Timely completion (traditionally no longer than 15 to 20 minutes) will allow for Dr. Yadava to spend the entirety of your appointment time with you. You will have an opportunity to expand on your answers when you are seen. Please do not leave any blanks. If there are questions that do not apply to you, please mark N/A. Thank you for helping us to serve you, as well as our other patients, in a timely manner.

IMPORTANT REMINDERS:

Please cancel or reschedule all appointments at least 24 hours in advance so that we may accommodate all patients in a timely fashion. No show appointments or cancellations **without** 24 hour notice will result in a $25 service fee.

Your copay and any applicable deductible or coinsurance is expected at the time of your visit. Please be aware that if you choose to pay for our services by credit/debit card, our credit card machine automatically adds a 4% service charge. However, if you choose to pay by cash, check or money order, there will not be a service fee added.

In order to serve our patients in a timely and comprehensive manner, we ask that you please bring in any **imaging study reports** and films (ie. x-rays, MRI, CT, etc.) that relate to your current medical issue. If you are being seen for your low back or lower extremities, you may bring your own shorts to wear for your examination.

We appreciate your cooperation. Thank you for helping us to serve you and all of our patients in a timely and efficient fashion.

DR. RAVI YADAVA
675 Old Ballas Road, Suite 210~ St. Louis, MO 63141
Ph: 314-994-WELL Fax: 314-994-0796
www.raviyadava.com

PERFORMANCE REHABILITATION & REGENERATION
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Dr. Ravi Yadava

Name_____ Appointment Date_____ DOB_____ Age____

Height_____ Weight_____ Handedness: RIGHT LEFT AMBIDEXTROUS

Primary Care Physician: _____

HISTORY OF ONSET

*Is this a work-related injury with an OPEN claim? YES NO
*Is this a motor vehicle-related injury with an OPEN claim? YES NO
*WILL you be filing a claim on either? YES NO
*If you had a PREVIOUS claim please give date closed: ____/____/_____

*Date of Onset of Symptoms _____

*How did this episode of pain begin?
_____
_____
_____
_____

*When did you first suffer serious pain?_____

*What time of the day is your pain the worst?_____

*How much of the time during an average day are you in pain?

___<4 hours per day
___ 4 to 8 hours per day
___ almost 24 hours per day
___ almost any time that I am not lying down

*How many days out of an average week do you have your usual pain?_____

*Please check which of the following make your pain worse:

___Bending forward ___Bending backwards ___Bending to the side
___Twisting ___Coughing ___Sneezing
___Walking ___Lying down ___Other

*What makes you feel better?_____

*Does your pain improve with exercise? YES NO

*Have you ever had any hospital admissions because of the pain? YES NO

*Have you ever had any emergency room visits because of the pain? YES NO

*Which of the following diagnostic tests have been done?
*Please list location & approximate date.

Plain X-ray _____
Myelogram _____
Bone Density Study _____
EMG/NCV_____
CT Scan _____
MRI Scan _____
Bone Scan_____
Nerve Block _____

TREATMENT

*Put a check next to each type of treatment you have had for your problem in the past.
*Circle the treatments you felt were beneficial.

____Hot packs
____Ultrasound
____Ice
____Massage
____E-Stim//TENS unit
____Body Mechanics Training
____Flexibility exercises
____Strengthening exercises
____Aerobic exercises
____Bed rest
____Inversion/Traction
____Chiropractic treatment
____Osteopathic manipulation
____Biofeedback/Biobehavioral hypnosis
____Trigger point injections
____Epidural injections
____Facet joint injections
____Brace
____Acupuncture
____Anti-inflammatory medication
____Narcotic pain medication
____Anti-depressant medication
____Muscle relaxant medication
____Manual Medicine/Manipulation/Bodywork

Other_____ (specify)

*Please list the physicians, chiropractors and/or osteopaths you have seen for your pain in the last 2 years, along with the approximate dates:

Type of doctor Doctor's name Location Date(s)
_____
_____
_____
_____

GENERAL HEALTH HISTORY

*Have you received an Influenza vaccination? YES NO Date: _____

*Have you had a Pneumococcal vaccination (if over 65)? YES NO Date: _____

*Do you have an allergy to Latex? YES NO Reaction: _____

+Do you have any known drug allergies? YES NO Drug/Reaction: _____
_____

*List all medications you have taken **in the <u>last six months</u>** including those "over the counter":
_____
_____

*List all medications you are **currently taking** including those "over the counter":

_____

_____

*Please list any medical problems you have (including those for which you take the above meds):

_____

_____

*Please list any previous surgeries including those of the neck or back:

_____

_____

*Do you have a history of cancer? YES NO Type: _____
*Have you had any unexplained weight loss? YES NO
*Have you had any fevers or night sweats? YES NO

*During the past month have you often been bothered by:

	YES	NO		YES	NO
Stomach pain	___	___	Shortness of Breath	___	___
Back pain	___	___	Dizziness	___	___
Pain in your arms, legs or joints	___	___	Nausea, gas or indigestion	___	___
Menstrual pain or problems	___	___	Feeling tired or low energy	___	___
Pain or problems during intercourse	___	___	Trouble sleeping	___	___
Your eating being out of control	___	___	Headaches	___	___
Little interest or pleasure in doing things	___	___	Chest pain	___	___
Constipation, loose bowels or diarrhea	___	___	Fainting spells	___	___
Feeling down, depressed or hopeless	___	___	Feeling heart pound/race	___	___
"Nerves" or feeling anxious or on edge	___	___	Worrying a lot about things	___	___

*Have you discussed these problems with your primary doctor? YES NO

*Overall you feel your health is: EXCELLENT VERY GOOD GOOD FAIR POOR

LIFESTYLE HISTORY

*Do you smoke cigarettes? YES NO *How many packs per day?_____

*Did you quit smoking? YES NO *If so, at what age?_____

*Has anyone in your family been on Disability? YES NO

*Did you finish high school? YES NO

*What IS your highest level or grade of education?_____

*Are you married? YES NO *Divorced? YES NO
*Ages of children:_____

*Do you have a history of drug abuse (prescription or "street" drugs)? YES NO

- Have you taken alcohol to control your pain? YES NO
- Have you ever used street drugs or controlled substances to control pain? YES NO

OCCUPATIONAL HISTORY

*Usual occupation:_____ Employer:_____ Date of Hire:_____

*Briefly describe your present job:

_____
_____

*Please list your job history for the last 10 years (including job type, employer & years at that job).

_____
_____
_____

*Work status at the time of ONSET OF PAIN:
____ Regular (full time)
____ Regular (part time)
____ Permanent light duty
____ Restricted light duty
____ On disability of time loss
____ Retired
____ Not currently in work force

*Work status TODAY:
____ Regular (full time)
____ Regular (part time)
____ Permanent light duty
____ Temporary light duty
____ On disability or time loss
____ Retired
____ Not currently in work force

* IF RESTRICTED, WHY?_____

*How physically demanding is your job?
____ Light ____ Moderate ____ Heavy ____ Very heavy ____ Not applicable

*How satisfied are you with your job?
____ Very satisfied ____ Satisfied ____ Dissatisfied ____ Worst job I've had

*Have you previously been off work due to this problem? YES NO

*If yes, about how many days of work have you missed due to pain in the last two years? _____

*When was the last time you worked?_____

*Has your employer treated you fairly? YES NO

*Before your present injury, had you ever filed an industrial claim? YES NO

*Does an attorney assist you with your injury claim? YES NO

FAMILY HISTORY

*Please list medical problems experienced by family members & which member(s) experiences it:

_____
_____
_____

PAIN HISTORY

1) Circle the number on the line below that represents your pain at its least.

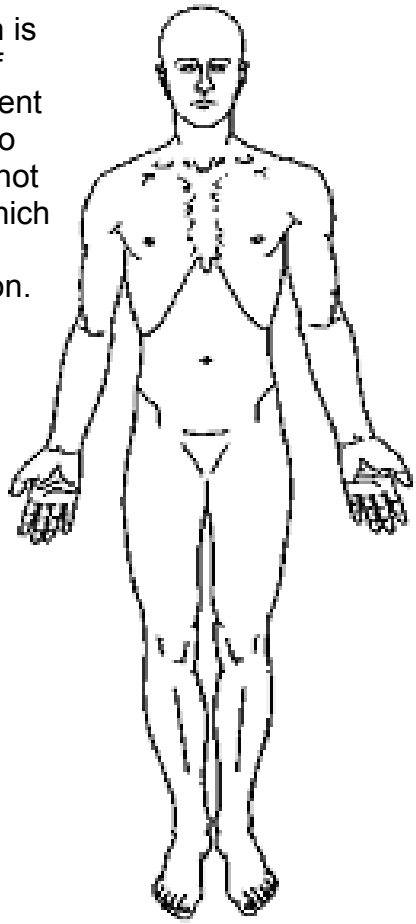
2) Circle the number on the line below that represents your pain at its worst.

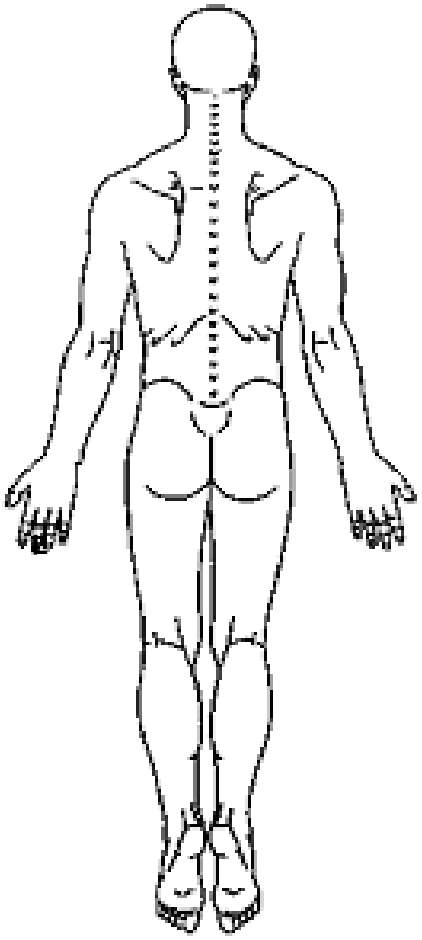
3) Place and "X" on the line below that represents your pain right now.

0	1	2	3	4	5	6	7	8	9	10
No pain			Moderate				Severe			Excruciating

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

/// Stabbing
xxx Burning
ooo Pins & Needles
=== Numbness
+++ Aching





*In each section, mark only the one box which applies to you. We realize you may consider that two of the statements in any one section related to you, but please just mark the box which most closely describes your problem.

SECTION 1: PAIN INTENSITY

___ I can tolerate the pain I have without having to use pain killers.
___ The pain is bad but I manage without taking pain killers.
___ Pain killers give complete relief from pain.
___ Pain killers give moderate relief from pain.
___ Pain killers give very little relief from pain.
___ Pain killers have no effect on the pain and I do not use them.

SECTION 2: STANDING

___ I can stand as long as I want without extra pain.
___ I can stand as long as I want but it gives me extra pain.
___ Pain prevents me from standing more than 1 hour.
___ Pain prevents me from standing more than ½ hour.
___ Pain prevents me from standing more than 10 minutes.
___ Pain prevents me from standing at all.

SECTION 3: LIFTING

___ I can lift heavy weights without extra pain.
___ I can lift heavy weight but it gives extra pain.
___ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned, e.g. on a table.
___ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
___ I can lift only very light weights.
___ I cannot lift or carry anything at all.

SECTION 4: WALKING

___ Pain does not prevent me walking any distance.
___ Pain prevents me walking more than 1 mile.
___ Pain prevents me walking more than ½ mile.
___ Pain prevents me walking more than ¼ mile.
___ I can only walk using a stick or crutches.
___ I am in bed most of the time and have to crawl to the toilet.

SECTION 5: SITTING

___ 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 more than 1 hour.
___ Pain prevents me from sitting more than ½ hour.
___ Pain prevents me from sitting more than ¼ hour.
___ Pain prevents me from sitting more than 10 minutes.
___ Pain prevents me from sitting at all.

SECTION 6: PERSONAL CARE

___ I can look after myself normally without causing extra pain.
___ I can look after myself normally but it causes extra pain.
___ It is painful to look after myself and I am slow and careful.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of self care.
___ I do not get dressed, wash with difficulty and stay in bed.

SECTION 7: SLEEPING

___ Pain does not prevent me from sleeping well.
___ I can sleep well only by using tablets.
___ Even when I take tablets I have less than six hours sleep.
___ Even when I take tablets I have less than four hours sleep.
___ Even when I take tablets I have less than two hours sleep.
___ Pain prevents me from sleeping at all.

SECTION 8: SEX LIFE

___ My sex life is normal and causes no extra pain.
___ My sex life is normal but causes some extra pain.
___ My sex life is nearly normal but is very painful.
___ My sex life is severely restricted by pain.
___ My sex life is nearly absent because of pain.
___ Pain prevents any sex life at all.

SECTION 9: SOCIAL LIFE

___ My social life is normal and gives me no extra pain.
___ My social life is normal but increases the degree of pain.
___ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g.
dancing, etc.
___ Pain has restricted my social life and I do not go out as often.
___ I have no social life because of pain.

SECTION 10: TRAVELING

___ I can travel anywhere without extra pain.
___ I can travel anywhere but it gives me extra pain.
___ Pain is bad but I manage journeys over 2 hours.
___ Pain restricts me to journeys of less than 1 hour.
___ Pain restricts me to short necessary journeys under 30 minutes.
___ Pain prevents me from traveling except to the doctor or hospital.

*Overall, satisfaction with your life is:

____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

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Patient Name :_____ DOB: _____ SSN: _____
(First Last MI)
Marital Status: S M W D Sex: M F Other _____

Address: _____
(Street) (City) (State) (Zip)
Phone: (Home)_____ (Work)_____ (Ext)_____

Optional: Cell Phone: _____ Email:_____ Fax:_____

Are you between 18 and 26 years of age and a full time student? YES NO
Have you treated with Dr. Yadava before? YES NO
Is condition related to: an auto accident ☐ a job injury ☐ liability accident ☐ no injury ☐

BODY PART: _____

DATE OF INJURY/SYMPTOMS ___/___/___
(specific date required by insurance companies)

Have you retained an attorney? YES NO
If YES, please provide information below:
Name: _____
Address: _____
_____
Phone: _____

Patient's Employer: _____ Spouse's Employer _____

Address_____ Address_____

Phone_____ Phone_____

Pharmacy Name/Zip Code/Ph #:_____

Must Be Completed

Primary Insurance Coverage	**Secondary Insurance Coverage**
Ins. Co._____	Ins. Co._____
ID # _____	ID # _____
Group # _____	Group # _____
Cardholder's Name_____	Cardholder's Name_____
Cardholder's DOB_____	Cardholder's DOB_____
Cardholder's SS# _____	Cardholder's SS#_____

EMERGENCY CONTACT (Relative/Friend not residing with you)

Name:_____ Phone:_____ Relationship:_____
Referred By:_____ Phone:_____

Did you bring any Medical Records or X-rays that you would like for Dr. Yadava to consider? Yes ☐ No ☐
(If yes, please present these to the receptionist immediately.)
I have reviewed the above information and it is accurate and current. **Please Initial and Date** _____
If you are under the age of 18, please have parent or guardian initial above and sign the consent form.

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CONSENT

I hereby authorize my Doctor (or whomever he may designate) to administer such medical treatment as is necessary for a patient in my condition.

I understand that any x-rays taken in this office are read and interpreted as a part of my care by Dr. Yadava. I understand that Dr. Yadava is not a radiologist and that if I wish to have my x-rays read by a radiologist that this will be accommodated upon request at my own expense.

I hereby authorize Performance Rehabilitation to furnish my Insurance Carrier(s), Attorney, Legal Representative and Referring and/or Consulting Health Care Providers all information concerning my present illness or injury.

I understand that I am financially responsible for any charges not covered by my insurance, and any charges incurred as a result of collection (i.e. Attorney fees, court costs and Collection Agency fees). ALL insurances/HRA/HSAs after my primary are MY responsibility to file and balances after said primary insurance are MY responsibility regardless if my secondary or HSA/HRA pay my claim(s) or not.

By signing below, I understand that all cell phones, tablets, etc. are required to be silenced at the time of service. I also understand that it is prohibited for any recording, including video or audio, to be taken while in the office.

Appointment confirmation: I wish to be contacted for confirmation of my appointments with Dr. Yadava by text message: _____. By providing our office with this information, you authorize consent to be contacted by the above stated method. Performance Rehabilitation is not directly charging you to receive these messages; however, standard message and data rates may apply.

Email update consent: I wish to sign up for emails regarding patient care updates, surveys, promotions, services, etc. at _____. I understand that I can opt out of these emails at any given time.

Cancellation policy: Please cancel or reschedule all appointments at least 24 hours in advance so that we may accommodate all patients in a timely fashion. No show appointments or cancellations without 24 hour notice will result in a $25 service fee.

Please be aware that if you choose to pay for our services by credit/debit card, our credit card machine automatically adds a 4% service charge. However, if you choose to pay by cash, check or money order, there will not be a service fee added.

There is a $35.00 service fee for all CHECKS RETURNED BY YOUR BANK for any reason; this is what our bank charges us.

A $5 per month service fee will be added to your account for all balances over 30 days old.

Assignment of Benefits: I hereby authorize payment of medical and surgical benefits, provided by the insurance carrier, to Performance Rehabilitation.

SIGNATURE **DATE**