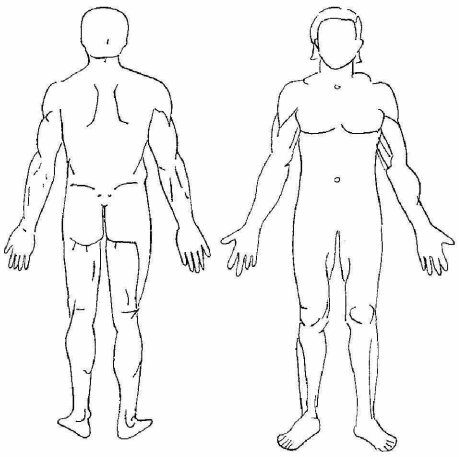
Please sign Telehealth Consent: _____ I consent to telehealth visit. I understand that in person appointments are available to schedule. I understand the visit will not be recorded and agree not to record it.

Patient Name:

Date: O Telemed Note

Please color in areas that you have pain



Dull ache, sharp
Burning, Stiff
Cold, hot, tightness
Off and on, shooting
Muscle spasm
Electrical, entire body
Worse in the morning
Worse in the afternoon
Worse in the evening
Worse at night
Pain constant
#1 pain draw line to
#2 pain draw line to

When did pain begin or increase?_____

Please circle on the line how severe your pain is today?

No pain Worst pain

0 1 2 3 4 5 6 7 8 9 10

What causes your pain to **increase**? _____
Sitting, standing, walking, twisting, bending, lifting, moving neck.

What causes your pain to **decrease**? _____
Sitting, standing, walking, laying down, injections, laser, medications.

How much did your pain decrease after the last injection or treatment?
Body Location? Date of injection:
Please circle: **0 10 20 30 40 50 60 70 80 90 100%**

Please circle what activities you can do.
Walk (less than 5 min) 5, 8, 10, 15, 20, 30, 45, 60 unlimited
grocery shop, house work, cook meals, do dishes, yard work, drive.
How many days have you missed last month due to pain?__
O I do not work outside the home.

Please circle if you had problems with:_____
Feeling too sleepy, problems sleeping, constipation, diarrhea, weakness in the hands, arms or legs, dizziness, headaches, Difficulty urinating, kidney problems, liver problems easy bruising, fever, cough, shortness of breath, exposure to sick people, decreased taste or smell appetite, irregular heartbeats, leg swelling, problems after injections.

Have you stopped or started any new medications?
Please list any changes: No Changes:_____

_____

Please circle and indicate how many you take per day? NONE
Tobacco products, Tylenol, Advil, Ibuprofen, Naproxen, Aspirin, Warfarin, Coumadin, Pradaxa, Fish or Flaxseed oil.

Do you take any blood thinners or Aspirin? Yes No
Have you been **prescribed antibiotics** in the last 2 weeks? **Yes No**

Your email address:

Your Cell phone number:

What would you like to discuss with Dr. Suelzle today?
Medication problem, procedure questions, **O Same RX**
I need a refill on my medications. (please list)

_____

_____

Height inches_____Weight _____
BP _____Pulse _____
RR _____Temp _____

O Billed O Note O Scanned this form to pp
O ERX Sent Date 2024
Last ERx Date _____
O same pharmacy O new
Urine drug screen last done date _____
Urine drug screen ordered mailed _____
Patient activity report last done date _____

Norco 10/325 5/325_____# per month
Percocet 10/325 5/325 _____ # per month
MS IR Contin 15 30 _____ # per month
Oxycodone IR CR 10 30_____ # per month
Fentanyl patch 12 25 mcg Q 48 72 hours 10 15 /month
Methadone 10 5 mg _____ # per month
Gabapentin 300 400 600 mg _____ # per month
Restoril 15 mg _____# per month
Ambien 5 10 mg_____# per month
Xanex 0.25, 0.5 mg _____# per month Valium

Supplements: Dr S **R**-Recommended **T**-currently taking
O No changes O Patient declines help with supplements
XLear Nasal Spray Xylitol, Grapefruit seed kills Covid-19
2 pack on Amazon use every 12 hours.
Country Life Vitamin D3 5,000 units 1 2 3 4 per day
Life extension Magnesium 500 mg 1 2 per day
Life Extension K2 supplement (only if not taking blood thinner)
Garden of Life raw Zinc 1 per day
Dr Best Vitamin C 1,000 mg 1 2 3 4 per day
Vitacost 15-35 Probiotics 1 2 3 4 per day
Now "brand" D- Mannose 500 mg 1-3 twice per day and to stop all artificial sweetners due to history of chronic recurrent urinary tract infections

Alert to All: President, Day of week, month, holiday, Dr S office City, Calm, Cooperative, tearful, upset, poor historian, Filled out Dr S / Grace, Spanish translated by Grace,
No slurred speech, mild, moderate severe pain behavior.
No Coughing/wheezing/short of breath **O Same Diagnoses**
ADEQ. CONTROL, INADEQ, IMPROVED, RESOLVED
Diagnosis: LDD, LUSM, TLM, LSS, LSTenosis, CDD, CTM, TN, MTH, RShoulderM, LShoulderM, RHandM, LHM, ThoracicRM, TLumbM, RLowerLeg, LLowerLeg, RAFootM, LAFootM, RThighM, LThighM, HipSE, INTercostal, ChestAWP, AbdominalBP, PHerpeticN, PeripheralN, PelvicPFemale, TMMjaw, ComplexRUpperExt, RightComplexRLeg, LeftComplexRLeg,

Text or call Grace at 909-981-0608
for appointments, or questions.

Please fill out email back to gsuelzle@protonmail.com. Or mail to office 4 days before. Or text, back a flash picture of this to Dr Suelzle

909-276-8845 2-3 days before due for a 30 day refill, then Dr Suelzle will call to discuss. (Fax back at **909-982-5327**)

O Tobacco education provided. O Anti-inflammatory diet texted.
O Cough/Nasal Congestion treatment info texted.
O Blender apple vegetable smoothie instructions texted.
O Dr S recommends trigger point injections in the office, Patient (O agrees / O declines.)
O Patient advised risk of ovedose, DUI, traffic accident, falls, fractures if taking pain, anxiety, sleep and cold mediations.,
Please add to diagnostic: X-ray report, MRI report, Urine drug screen report. Patient text summary To note. gsuelzle MD 7-25-24