Rehabilitation, Sports & Spine Center

New Patient Form

NAME: _____

BIRTHDATE: _____ DATE: _____

MAIN CONCERNS: 1. _____

2. _____

3. _____

What do you think is causing your pain? _____

_____

1) Associated with a specific injury: _____Yes _____No Date of injury_____

If yes, briefly describe injury, including place of injury.

2) Initial and ongoing treatment practitioners: Dates:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

3) How did it start?

Gradually over weeks_____ Over days_____ Suddenly_____ Other_____

4) Have you ever had problems with this injury? _____ Yes _____ No

5) How many times have you visited a medical doctor in the past for this problem?

_____Never 1 to5 times _____6 to 10 times _____11 to 20 times _____More than 20 times

6) Have you ever had surgery for this problem? _____

Pain Severity

1) If 10 is the worst pain imaginable and 0 is no pain, please note your pain over the last two weeks.

a. Rate your WORST pain: 0 1 2 3 4 5 6 7 8 9 10

b. Rate your LEAST pain: 0 1 2 3 4 5 6 7 8 9 10

c. Rate your overall or Average pain: 0 1 2 3 4 5 6 7 8 9 10

2) How would you rate your overall severity of pain?

_____ Mild nuisance pain _____ Mild to Moderate, but I can live with it

_____Moderate, but I am having difficulty dealing with it

_____ Severe, it is ruining my quality of life

3) How is your pain today compared to when your pain started?

_____ Much improved _____ Somewhat improved _____ No change

_____ A little worse _____ Much worse _____ N/A

4) Any numbness? Yes_____ No_____ Where _____

5) Any tingling? Yes_____ No_____ Where _____

6) Any weakness? Yes_____ No_____ Where _____

7) Night pain? A lot _____ A little _____ No _____ Other_____

How much sleep do you get? _____

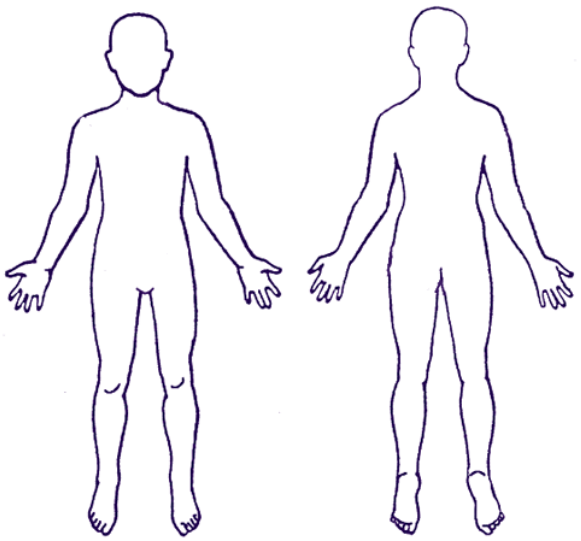
8) Maximum amount you can:

Sit _____Minutes _____Hours Lift _____Pounds

Stand _____Minutes _____Hours Walk _____Minutes _____Hours

9) Location of Pain: please fill out the figure to give pain location (shade affected areas with pen to show pain)

Describe location further if needed: _____



R L L R

10) Treatments:

Physical Therapy _____ Injections _____ Chiropractic _____ Massage _____

Acupuncture _____ Narcotics (Vicodin, Percocet, Tylenol #3, Demerol) _____

Anti-inflammatories _____ Muscle Relaxers _____ Anti-depressants _____

Benzodiazepates (Valium, Klonapin) _____

11) Rank these in order of comfort:

	Feels OK	Not bad	Worse	The Worst
Sitting	_____	_____	_____	_____
Standing	_____	_____	_____	_____
Walking	_____	_____	_____	_____
Lifting	_____	_____	_____	_____
Lying Down	_____	_____	_____	_____
Reaching	_____	_____	_____	_____
Bending	_____	_____	_____	_____
Static Positions	_____	_____	_____	_____

PREVIOUS DIAGNOSTIC EVALUATIONS:

MRI's: _____ Bone Scans: _____

CT's: _____ Myelograms: _____

X-Rays: _____ EMGs: _____

MEDICATIONS:

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

Allergies to Medicines: _____

PAST MEDICAL CONDITIONS:

Injuries:	Conditions/Illnesses:	Surgeries:
1)_____	1)_____	1)_____
2)_____	2)_____	2)_____
3)_____	3)_____	3)_____
4)_____	4)_____	4)_____

FAMILY MEDICAL HISTORY

List any medical problems that run in your family:

□ Diabetes □ Stroke □ Heart Disease □ Breast Cancer □ Cancer

□ Neurologic Disorders □ Pain Problems

Other _____

SUPPORT PERSONNEL

Vocational Counselor_____

Claims Manager_____

Legal Counsel? Yes_____ No_____ Name_____

SOCIAL HISTORY

A. Family Profile

Marital Status: Married_____ Single_____ Divorced_____ Widowed____

How many times have you been married? _____

Children? Ages: _____

Psychosocial:

□ Depression □ Substance Use □ Post Traumatic Stress Disorder □ Spouse/Child Abuse Hist

B. Education

Educational level attained_____ GED_____

Learning disabilities (dyslexia, etc.)_____

C. Military

Yes_____ No_____ Branch_____ Type of discharge_____

D. Vocational Training/Schooling_____

E. Work History

Are you off work as the result of your injury/illness? _____Yes _____No

Current employment Status: Full Time_____ Part Time_____

Full Duty_____ Light Duty_____ Modified Duties___

Last Date Worked: _____

Current Employer: _____ How Long: _____

Do you wish to return to work to your previous employer? Yes_____ No_____

Is your job in jeopardy? Yes___ No____ If you are off work, is your current job available?

_____Yes _____Doubt it _____NA _____Probably _____Definitely not

Prior Work Experience (last ten years):

1)_____

2)_____

3)_____

4)_____

5)_____

On a scale of 0 to 10, how much trouble do you think you will have sitting or standing long enough to do your job, six weeks from now. Think of 0 as meaning no trouble at all sitting or standing, and 10 meaning so much trouble sitting and standing that you won't be able to do your job at all.

1 2 3 4 5 6 7 8 9 10

On a scale of 0 to 10, how well do you get along with your co-workers? Think of 0 as meaning you don't get alone well at all and 10 meaning you get along very well.

1 2 3 4 5 6 7 8 9 10

On a scale of 0 to 10, how certain are you that you will be working in six months? Think of 0 meaning not at all certain, and 10 meaning very certain.

1 2 3 4 5 6 7 8 9 10

How physically demanding if your job?

_____ Very heavy (frequently lifting more than 100 pounds)

_____ Heavy (frequently lifting more than 60 pounds)

_____ Moderate (frequently lifting more than 30 pounds)

_____ Light (frequently lifting less than 30 pounds)

_____ Sedentary (essentially no lifting)

How satisfied are/were you with your job?

_____ Very satisfied _____ Satisfied _ Dissatisfied _____ It's the worst job I've ever had

F. Time Loss Compensation

Are you currently receiving time loss benefits? Yes_____ No_____

Are you currently receiving disability benefits? Yes_____ No_____

Are you currently receiving social security benefits? Yes_____ No_____

Are you currently receiving unemployment benefits? Yes_____ No_____

Are you currently receiving general assistance (DSHS)? Yes_____ No_____

G. Habits

Alcohol Daily_____ Weekly_____ Monthly_____ Not at all_____

Have you ever

Felt you should cut down on your drinking?_____Yes _____No

Felt annoyed by others criticizing your drinking? _____Yes _____No

Felt badly or guilty about your drinking? _____Yes _____No

Had a drink first thing in the morning to steady your nerves or get rid of a hangover? ___Yes ___No

Tobacco Packs per day_____ Duration_____ Not at all_____

Other Drugs: (circle) Marijuana Cocaine Amphetamine Heroin

Are you experiencing any of the following symptoms?

General	Yes	No
Fevers		
Chills		
Weight loss		
night sweats		
fatigue		
loss of appetite		
Ears/Hearing		
Loss of hearing		
Breathing/Respiratory		
Cough		
Shortness of breath		
Pain with breathing		
Muscle/Skeletal		
Joint pain/swelling		
Loss of motion in joints		
Frequent falls		
Heart/Cardiovascular		
Chest pain		
Heart murmur		
Fingers/toes sensitive to cold		
Abnormal heartbeat		
High blood pressure		
Calf cramping		
Swelling in legs		
Neurological		
Severe or frequent headache		
Dizziness or fainting spells		
Seizures or convulsions		
Memory difficulties		
Nose & Throat		
Difficulty swallowing		
Ulcerations		
Hematopoietic System		
bleeding		
anemia		

	Yes	No
Eyes/Vision		
double or blurred vision		
Urinary		
bloody urine		
flank pain/painful urination		
frequent urination		
urinary retention		
bladder incontinence		
Genital-Female		
Are you pregnant?		
genital pain		
difficulty in sexual functioning		
abnormal pap smear		
breast lumps		
Uterine fibroids or tumors		
Genital-Male		
abnormally of testicles		
difficulty in sexual functioning		
Stomach & Intestines		
frequent nausea or vomiting		
bloody or black vomitus		
stomach, abdominal, bowel pain		
blood in stools/hemorrhoids		
black stools		
bowel accidents		
constipation		
Diarrhea		
Emotional/Psychological		
recurrent feeling of loneliness		
excessive worry or anxiety		
frequent nightmares		
Panic attacks		
sleep disturbance		
depression		
poor concentration		
Decreased interest		
Crying episodes		
Endocrine		
Abnormal blood sugar		
Thyroid problems		
Diabetes		
Excessive thirst		

E

OFFICE USE ONLY BELOW THIS LINE

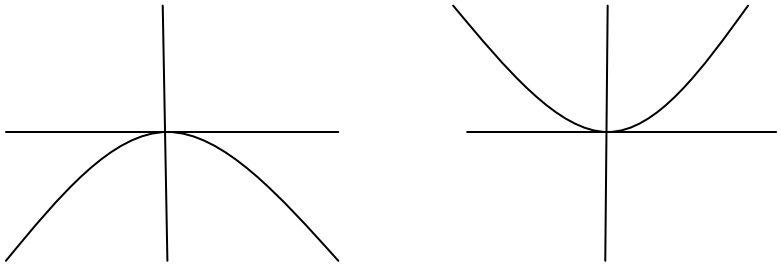
EXAM:

Height: _____ Weight: _____ BP:_____ Pulse: _____

General Appearance: _____

Skin: _____ Digits/Nails: _____ Pulses: _____

Gait & Station: _____



Palpation _____

SLR_____ Slurping _____ FABER_____ Pyriformis Stretch _____ SI Stress _____

Femoral Stretch _____ Finklesteins _____ Adsons _____ Resisted W/E _____

Resisted Hip Apd _____ Other _____

	DI	FE	WE	APB	EF	EE	SH	ABD	SH	ER	SUPRA
R											
L											

	HF	KE	KF	ADF	EHL
R					
L					

R Sensory: _____

L

Impression:

1)
2)
3)

Recommendations:

1)
2)
3)
4)