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Professional Corporation
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Board Certified, Physical Medicine
& Rehabilitation

Patient Name: _____

DOB: _____

INITIAL PATIENT QUESTIONNAIRE – PHYSICAL MEDICINE AND REHABILITATION

Date: _____

Patient Address: _____

Home Phone: _____ Work Phone: _____

Age: _____ Height: _____ Weight: _____ lbs. ☐ Male ☐ Female

Referring Physician: _____

What is the goal of your visit today? _____

CHIEF COMPLAINT:

Do you have any of the following?

Neck Pain ☐ Yes ☐ No
Shoulder Pain ☐ Yes ☐ No
Arm Pain ☐ Yes ☐ No
Elbow Pain ☐ Yes ☐ No
Upper Back Pain ☐ Yes ☐ No

Low Back Pain ☐ Yes ☐ No
Hip/Leg Pain ☐ Yes ☐ No
Knee Pain ☐ Yes ☐ No
Ankle/Foot Pain ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Pelvic Pain ☐ Yes ☐ No

Any other complaints: _____

If more than one area which is worse: _____

How long have you had this problem: _____

Did your symptoms follow an injury: _____ If yes, please indicate ☐ Auto Accident ☐ Work ☐ Other

Date of Injury: _____ Date of Surgery if applicable: _____

Briefly describe how you were injured: _____

How many hours in a 24 hour day do you experience pain: _____

Circle the number that corresponds to your pain levels over the past 2 weeks:

AT BEST: None 0 1 2 3 4 5 6 7 8 9 10 (WORST IMAGINABLE PAIN)

AT WORST: None 0 1 2 3 4 5 6 7 8 9 10 (WORST IMAGINABLE PAIN)

Describe your pain:

□ Constant	□ Dull	□ Stiffness
□ Intermittent	□ Shooting	□ Burning
□ Deep	□ Sharp	□ Throbbing
□ Aching	□ Cramping	□ Stabbing

During what time of the day are your symptoms at their best: _____

Is your pain worse (check one):

□ At night
□ In the morning
□ End of the shift/day
□ On a wet/cloudy day
□ No difference between night and day

Indicate which of the following activities Increase (I) or Decrease (D) your pain:

When I first get out of bed _____
Getting up _____
Sitting _____
Lying on my back/side _____
Leaning forwards _____
Lifting/bending forward _____
Straining _____
Look up/turn head sideways _____
Climbing stairs/walking up ramp or hill _____
Long car rides _____
Standing_____
Walking _____
Bending back _____
Lying on stomach _____
Coughing or sneezing _____
Twisting _____
Reaching over _____
Washing/combing hair _____
Other _____

Have you had neck/back symptoms before? □ Yes □ No

Have you had previous back or neck surgery? □ Yes □ No if yes, describe: _____

Have you had prior episodes of back symptoms for which you received Workman's Compensation? □ Yes □ No

Is the purpose of this exam to determine disability status for the government or insurance agency? □ Yes □ No

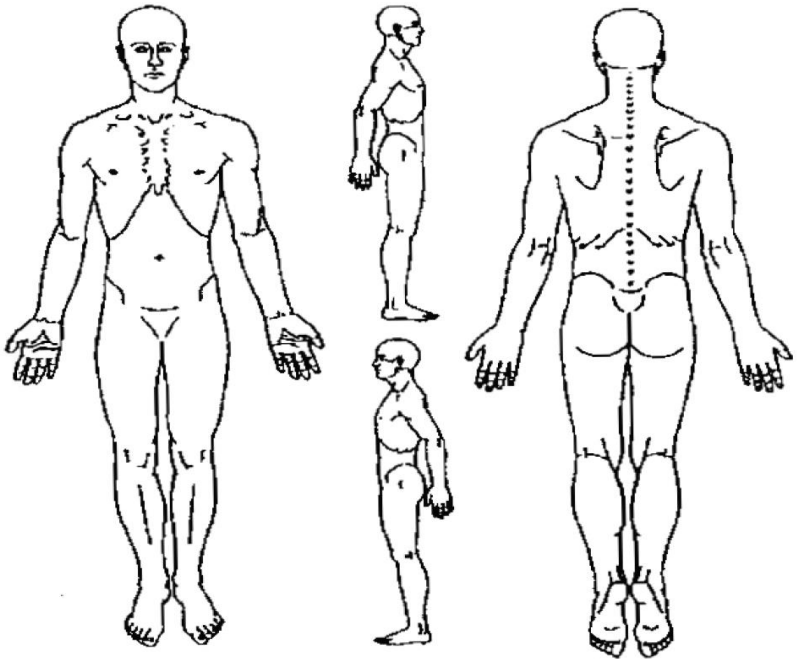
Do you have an attorney for your back problem? □ Yes □ No

PREVIOUS IMAGING:

DATE *LOCATION* (example: Dean Clinic)

MRI: _____
CT Scan: _____
Myelogram: _____
Bone Scan: _____
EMG : _____
X-rays: _____

Mark in the areas of your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols as indicated below.



SEVERE PAIN	*******
MODERATE PAIN	00000000
DULL ACHE	∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

PREVIOUS TREATMENT:

Put a check next to each type of treatment you have had for your back/neck in the past. Then check the column that best describes the effect of the treatment.

Treatment	*(√) if you have had:*	*Where* (*optional):*	*Did it make things (√)*		
			Better	Worse	No Change
Hot Packs/Ice	_____	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____	_____
Massage	_____	_____	_____	_____	_____
Tens/electrical stimulation	_____	_____	_____	_____	_____
Yoga/Tai-Chi	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____
Traction	_____	_____	_____	_____	_____
Bed rest	_____	_____	_____	_____	_____
Pool Therapy	_____	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____	_____
Braces/splints	_____	_____	_____	_____	_____
Medication	_____	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____	_____
Chiropractic Adjustment	_____	_____	_____	_____	_____
Osteopathic Manipulative Treatment (OMT)	_____	_____	_____	_____	_____

Injections:

Steroid Injections	_____	_____	_____	_____	_____
Trigger Point Injections	_____	_____	_____	_____	_____
Prolotherapy Injections	_____	_____	_____	_____	_____

MEDICAL HISTORY: Have you ever had:

- ☐ AIDS or HIV
- ☐ Stroke
- ☐ Seizures
- ☐ Migraine/or severe head pain
- ☐ Diabetes
- ☐ Phlebitis
- ☐ Arthritis
- ☐ Radiation/Chemotherapy
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Cancer
- ☐ Kidney Infections
- ☐ Tuberculosis
- ☐ Chronic fatigue syndrome
- ☐ Asthma/Breathing problems
- ☐ Thyroid trouble
- ☐ Ulcer
- ☐ High Blood Pressure
- ☐ Hearth Attack
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis

☐ Other – if you have other medical conditions please list them below :

1. _____
2. _____
3. _____

REVIEW OF SYSTEMS: √ all that apply

Constitutional
Fever _____
Chills _____
Night sweats _____
Weight loss _____
Loss of appetite _____

Allergy/Immune
Drug allergy _____
Seasonal allergy _____
Food Allergy_____
Iodine allergy _____
Transplant _____

Neurological
Paralysis _____
Tremors _____
Spasticity _____
Seizures _____
Muscle atrophy _____
Weakness (specify location) _____
History of brain or spinal cord injury _____

Musculoskeletal
Joint stiffness/swelling _____
Muscle pain/swelling ____
Fatigue _____
Fractures _____

Hemo-lymphatic
Anemia _____
Excessive bleeding _____
Easy bruising _____
Lymphoma _____
Leukemia _____
Cancer _____
Lymph node swelling _____

CV/Respiratory
Shortness of breath _____
Wheezing _____
Cough _____
Coughing up blood _____
Chest Pains _____
Palpitations _____
Leg swelling _____

Gastrointestinal
Difficulty swallowing _____
Heartburn _____
Nausea/vomiting _____
Constipation _____
Diarrhea _____
Blood in stools _____
Stomach pain _____
Bowel Incontinence _____

Endocrine
Obesity _____
Thyroid Disorder _____
Diabetes _____
Menopause _____
Menstrual irregularities____
Pelvic pain _____
Addison's disease _____

HEENT
Loss of vision _____
Eye Redness _____
Headaches_____
Dizziness _____
Glaucoma _____

Skin/Integumentary
Rash _____
Ulcer _____
Eczema _____
Hives _____

Genitourinary
Pain urinating _____
Incontinence _____
Blood in urine _____
Dribbling _____
Sexual Difficulties _____
Pregnant _____; LMP _____

Psychiatric
Poor sleep _____
Depression _____
Anxiety _____
Stress at work/home _____
Panic Spells _____

PAST SURGICAL HISTORY:

Year: Operation: Place Hospitalized:

_____

_____

_____

_____

_____

_____

If you had previous surgery for your back, neck, or another joint (ex. Knee; Ankle, etc.):

Note: If you have had multiple surgeries, please describe the ones related to today's visit.

What were your symptoms before the surgery? (indicate **R** for right side, **L** for left side, **B** for both sides and circle all that applies) :

Neck Pain _____
Shoulder pain/numbness/weakness__ ___
Arm pain/numbness/weakness _____
Wrist/hand pain/numbness _____
Back Pain _____
Hip/buttock/thigh pain/numbness/weakness _____
Other – please specify _____

Leg pain/numbness/weakness _____
Ankle/foot pain/numbness/weakness _____
Urinary complaints _____
Bowel Complaints _____
Impotence _____
Walking/gait disturbances _____
Balance/falls/clumsiness _____

Did your symptoms improve after surgery? _____ If yes, how long afterwards? _____

Did you get worse after surgery? _____ If yes, explain: _____

Were you released back to work after surgery? _____ If so, when? _____

MEDICINES:

List all medicines that you have taken recently. Include vitamins, supplements, herbs, and non-prescription medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ALLERGIES:

Name of medicine/substance *Type of reaction* *Date*

_____

_____

_____

_____

FAMILY HISTORY:

Spinal Problems ☐ Yes ☐ No If yes, describe: _____

Bleeding Disorders ☐ Yes ☐ No If yes, describe: _____

Heart Disease ☐ Yes ☐ No If yes, describe: _____

Cancer ☐ Yes ☐ No If yes, describe: _____

Diabetes ☐ Yes ☐ No If yes, describe: _____

Other ☐ Yes ☐ No _____

SOCIAL HISTORY:

How many years of schooling ? (circle one)

Less than high school high school graduate technical school diploma 1-3 years of college

College graduate post graduate or professional degree

Marital Status:

Single _____ Married _____ Divorced _____ Remarried _____

Widowed _____ Separated _____

How many years? _____

Number of children? _____ Ages: _____

Who lives with you at home? _____

Working status: ☐ Working ☐ Not Working ☐ Student ☐ Disabled ☐ Retired

Primary Occupation: _____ Employer: _____

How long have you worked at your present job? _____ If not working, last date worked: _____

Spouse's Occupation: _____

Have you ever smoked? ☐ Yes ☐ No Type/Amount: _____ Years: _____ If quit, when? _____

Amount of alcohol consumed in a typical week? _____ Cups of caffeinated drinks per day? _____

Have you used: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other:_____

Do you exercise regularly? Describe type of exercise, frequency/how often, and duration (ex. Walk three times a week for 30 minutes) _____

How many hours of sleep per night do you get on average? _____

How would you describe the quality of your sleep? _____

Thank you for filling this intake form out, please bring it with you on your appointment.

Completed By :_____

Date: _____

If not completed by patient, relationship to patient: _____

Office Use Only:

MRN: _____

Reviewed by: _____ *Date:* _____