2121 North 1700 West Layton, UT 84041 (801)773-4840

Dr. Benjamin Humpherys

Physical Medicine & Rehabilitation ("Physiatry")

NEW PATIENT INFORMATION

NAME: ______________________________ AGE: ________ DATE: ________________

DATE OF BIRTH: ______________________ HT: ____________

WHO REFERRED YOU? __________________ WT: ____________

BP: ____________

P: ____________

Are you: ☐ Male ☐ Female

☐ Right handed ☐ Left handed ☐ Ambidextrous

CHIEF COMPLAINT:

Reason for visit: ____

Location of your pain:

☐ Head ☐ Shoulder ☐ Mid Back ☐ Leg ☐ Neck ☐ Headaches ☐ Low Back ☐ Arm

HISTORY OF PRESENT ILLNESS:

Date of symptom onset: ______________________

Type of injury: ☐ Sports Injury ☐ Job Accident

☐ Car Accident (Were you the ☐ Driver or ☐ Passenger? Seatbelted? ☐ No ☐ Yes)

☐ Other (explain): ____

Please describe how you hurt yourself/How your symptoms began: ______________________________

____

____

____

____

Please describe your current symptoms: ____

____

____

____

____

On a scale of 0 – 10 circle the number that corresponds to the **severity** of your pain.
("0" means no pain and "10" is the worst pain you can imagine.)

At its worst:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10

Which of the following best describes the **character** of your pain?

Timing:
- ☐ Continuous, steady, constant
- ☐ Rhythmic, periodic, intermittent
- ☐ Brief, momentary, transient
  (Frequency: _____ Duration: _____)

Quality:
- ☐ Throbbing ☐ Burning ☐ Superficial
- ☐ Aching ☐ Tingling/numbness ☐ Deep
- ☐ Sharp ☐ Dull

What makes your pain **worse**? ________________________________

What makes your pain **better**? ________________________________

How long/far can you: Sit ____________ Stand ____________ Walk ____________

Since the onset of your symptoms, is your pain: ☐ Better ☐ Same ☐ Worse

If your pain is changed, by what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ☐No ☐ Yes

PREVIOUS TREATMENT

Have you had treatment since your injury? ☐ No ☐ Yes Have you been to the ER for this? ☐ No ☐ Yes

Have you had any of the following tests or procedures performed?

- X-rays ☐ No ☐ Yes
- MRI ☐ No ☐ Yes
- Epidurals/Injections ☐ No ☐ Yes
- CT Scan ☐ No ☐ Yes
- EMG ☐ No ☐ Yes
- Surgeries ☐ No ☐ Yes

Other (please explain) ________________________________

MEDICAL

Dr. ____________ Date of 1st visit ____________ Last visit ____________
Diagnosis given ________________________________
Medications given ________________________________
Treatment provided ________________________________

CHIROPRACTIC ☐ No ☐ Yes
Dr. ____________ Date of 1st visit ____________ Last visit ____________
Diagnosis given ________________________________

Frequency: ☐ Daily ☐ Three times/week ☐ Two times/week ☐ Weekly

Has it helped? ☐ No ☐ Yes

PHYSICAL THERAPY ☐ No ☐ Yes
Therapist ____________ Date of 1st visit ____________ Last visit ____________

Has it helped? ☐ No ☐ Yes Home exercise program given? ☐ No ☐ Yes

CURRENT MEDICATIONS:

NAME	DOSAGE	HOW OFTEN DO YOU TAKE?
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________

MEDICATION ALLERGIES ☐ No ☐ Yes

If yes, please list: Name: Reaction:

Name	Reaction
_____________	________________________________
_____________	________________________________
_____________	________________________________
_____________	________________________________

Are you allergic to or had any reaction to iodine, shellfish, IVP dye, or contrast media? ☐ No ☐ Yes

PAST MEDICAL HISTORY

☐ Anxiety	☐ Heart Attack	☐ Polio	☐ Thyroid trouble	☐ Depression
☐ Asthma	☐ Heart Murmur	☐ Stroke	☐ High Cholesterol	☐ Alcoholism
☐ Cancer	☐ Lung Disease	☐ Parkinson's	☐ Rheumatic Fever	☐ Hepatitis
☐ Diabetes	☐ Ulcers/PUD	☐ Arthritis	☐ Claustrophobia	☐ High Blood Pressure

☐ Other conditions ____

Have you ever had similar symptoms/injury before? ☐ No ☐ Yes

If yes, when: __________________________ Please describe briefly: ________________

____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐ No ☐ Yes

If yes, please list type of surgery and approximate date:

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

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

☐ Anxiety	☐ Heart Attack	☐ Polio	☐ Thyroid trouble	☐ Depression
☐ Asthma	☐ Heart Murmur	☐ Stroke	☐ High Cholesterol	☐ Alcoholism
☐ Cancer	☐ Lung Disease	☐ Parkinson's	☐ Rheumatic Fever	☐ Hepatitis
☐ Diabetes	☐ Ulcers/PUD	☐ Arthritis	☐ Claustrophobia	☐ Back Problems

☐ Other ____

SOCIAL HISTORY
Marital Status: (Check one or more)

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ "Living together" ☐ Separated

Number of Children: __________ Ages: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Do you smoke? ☐ No ☐ Yes How much? ______________________

Previous smoker? ☐ No ☐ Yes When stopped? ______________________

Do you drink alcohol? ☐ No ☐ Yes How much? ______________________

Coffee, tea, cola beverages (cups/glasses/cans per day) ______________________

Do you use recreational drugs? ☐ No ☐ Yes What type/how often? ______________________

Are you currently employed? ☐ No ☐ Yes If yes, type of job ______________________

REVIEW OF SYSTEMS: Please mark those items which you currently experience:

GENERAL

☐ Fever ☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Chills

☐ Weakness ☐ Night sweats

DERMATOLOGY

☐ Jaundice ☐ Itching/rash ☐ Lesions ☐ Easy bruising

HEAD/HEARING & VISION

☐ Trauma ☐ Headaches ☐ Tenderness ☐ Dizziness

☐ Ringing in ears ☐ Blindness ☐ Blurred vision ☐ Changes or hearing loss

☐ Discharge ☐ Rings around lights ☐ Double vision ☐ Light sensitivity

☐ Glasses

PULMONARY

☐ Wheezing ☐ Shortness of breath ☐ Chronic cough ☐ Coughing up blood

CARDIOVASCULAR

☐ Chest pain ☐ Leg swelling ☐ Shortness of breath with exertion ☐ Racing heart

GASTROINTESTINAL

☐ Nausea ☐ Abdominal pain ☐ Bloody stool ☐ Constipation ☐ Diarrhea

GENITOURINARY

☐ Blood in urine ☐ Vaginal discharge ☐ Pregnancy ☐ Pain/burning on urination

☐ Incontinence ☐ Venereal disease ☐ Sexual problems

☐ Painful menstruation ☐ Menopause ☐ Urgency/frequency with urination

☐ Irregular menstruation

MUSCULOSKELETAL

☐ Arthritis ☐ Joint swelling ☐ Trauma

NEUROLOGICAL

☐ Loss of sensation ☐ Seizures ☐ Numbness and tingling

PSYCHOLOGICAL

☐ Sadness ☐ Anxiety ☐ Depression

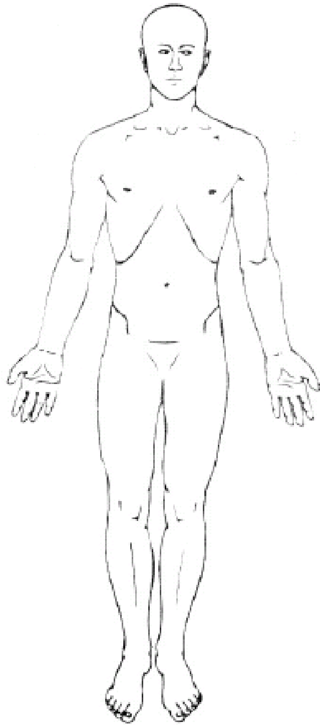
TANNER CLINIC

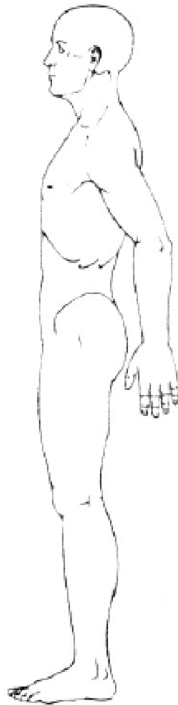
Mark on the pictures below, the areas of your body where you feel the described sensation. Use the symbols listed. Mark the areas of radiating pain or numbness as well. Include all affected areas.

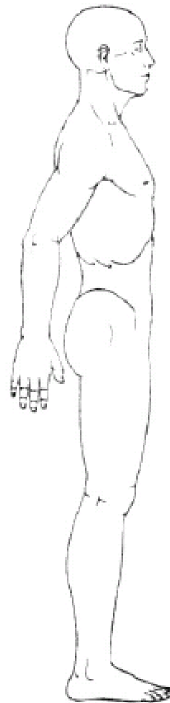
Symbols:

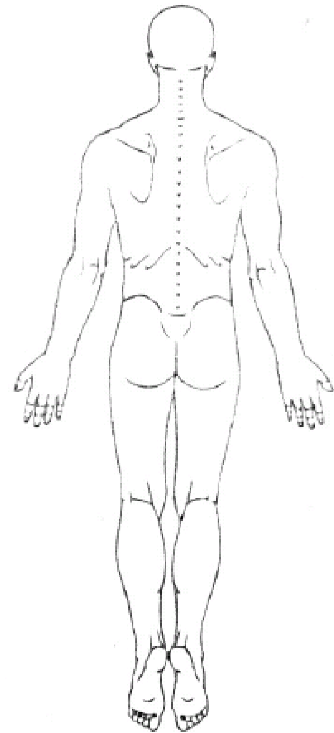
Numbness	Tingling	Burning	Stabbing/Sharp	Aching	Cramping
o o o	: : :	x x x	/ / /	^ ^ ^	□ □ □

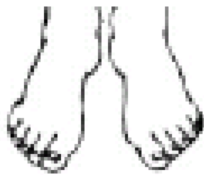
Front   Left   Right   Back

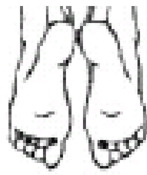












R   L   L   R   R   L   L   R