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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:

<u>NAME</u>	<u>DOSAGE</u>	<u>HOW OFTEN DO YOU TAKE?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALLERGIES No Yes

If yes, please list: 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 High Blood Pressure Arthritis Claustrophobia Ulcers/PUD
- 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

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
o o o

Tingling
: : :

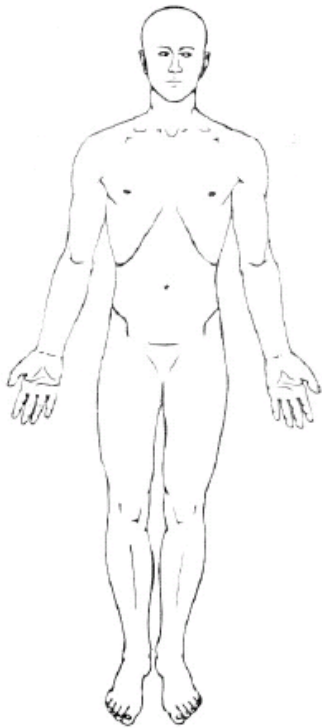
Burning
x x x

Stabbing/Sharp
/ / /

Aching
^ ^ ^

Cramping
□ □ □

Front



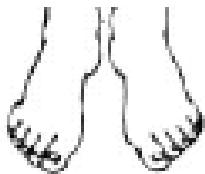
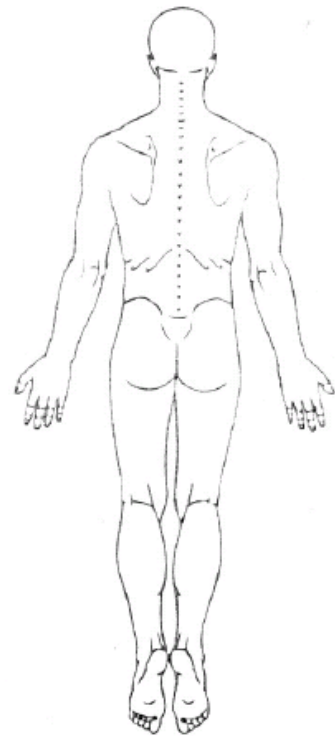
Left



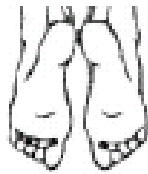
Right



Back



R L



L R



R L L R