The Rehab Doctors PC

PHYSICAL MEDICINE / PAIN MEDICINE
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Name: _____ Today's Date: _____

Date of Birth: _____ Age:_____ Gender: M / F Handedness: Right / Left

Were you referred by a physician? ☐ Yes ☐ No Physician's Name: _____

What problem are we seeing you for today? _____

When did the current problem begin? _____Is it getting? Better / Worse / No change

Have you had similar problems in the past? ☐ Yes ☐ No Explain:_____

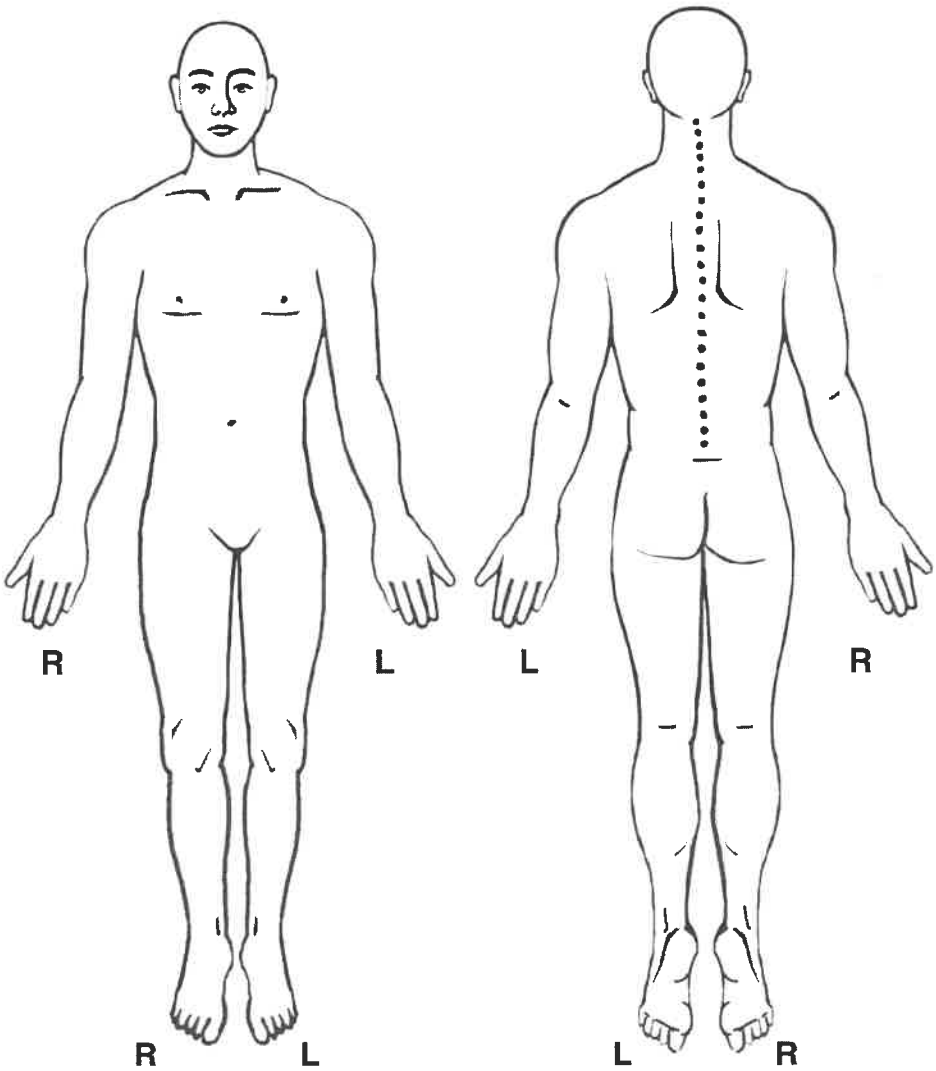
How did this problem begin? _____

_____

Is this problem covered under Workers Compensation? ☐ Yes ☐ No

Do you currently have work restrictions? ☐ Yes ☐ No Explain:_____

PLEASE DRAW YOUR PAIN BELOW



Pain Description

How would you describe the pain?

☐ Sharp ☐ Dull/Ache ☐ Burning ☐ Pressure ☐ Other_____

Circle the number that corresponds with your pain level (0 = no pain, 10 = incapacitating pain)

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

At what time of day do you have:

The least pain_____ The most pain_____

Or N/A – my pain: ☐ is constant ☐ has no relation to time

Does the pain ever wake you up from sleep? ☐ Yes ☐ No

What makes your pain worse? (please check all that apply)

☐ Lying down ☐ Sitting ☐ Standing ☐ Lifting ☐ Bending ☐ Twisting

☐ Walking ☐ Running ☐ Coughing ☐ Sneezing ☐ Straining ☐ Other:_____

What makes your pain better? (please check all that apply)

☐ Sitting ☐ Lying ☐ Walking ☐ Ice ☐ Heat ☐ Medications ☐ Other: _____

Do you experience any of the following? (please check all that apply)

☐ Pain radiating down arm or leg (Where: _____)

☐ Numbness (Where: _____)

☐ Tingling (Where: _____)

☐ Muscle spasms (Where: _____)

☐ Weakness (Where: _____)

☐ Bowel Accidents ☐ Bladder Accidents

If you have back and/or leg pain, what percentage of your pain is in your back versus your leg?

☐ 100% back ☐ 75% back/25% leg

☐ 50% each ☐ Not sure

☐100% leg ☐ 75% leg/25% back

If you have neck and/or arm pain, what percentage of your pain is in your neck versus your arm?

☐ 100% neck ☐ 75% neck/25% arm

☐ 50% each ☐ Not sure

☐100% arm ☐ 75% arm/25% neck

Which activities are significantly limited because of this problem?

☐ Sleep ☐ Eating ☐ Dressing ☐ Bathing ☐ Toileting ☐ Walking ☐ Stairs

☐ Cooking ☐ Picking an object up off the floor ☐ Lifting ☐ Reaching

☐ Shopping ☐ Socializing ☐ Driving ☐ Working ☐ Exercise

Other:_____

Treatment History

Have you seen another doctor for THIS problem? ☐ Yes ☐ No

If yes, who?_____

What types of testing have you had for this problem? (check all that apply)

☐ I have had no diagnostic testing for this problem

☐ X rays Body part(s): _____ When: _____

☐ MRI Body part(s): _____ When: _____

☐ CT scan Body part(s): _____ When: _____

☐ Myelogram Body part(s): _____ When: _____

☐ Discography Body part(s): _____ When: _____

☐ Bone scan Body part(s): _____ When: _____

☐ Nerve Test/EMG Body part(s): _____ When: _____

What Medications have you tried for THIS problem? (please check all that apply)

☐ Tylenol ☐ Aspirin

☐ NSAIDS (Please check those which you have tried for this problem)

☐ Ibuprofen (Motrin) ☐ Naproxen (Aleve) ☐ Oxaprozin (Daypro)

☐ Meloxicam (Mobic) ☐ Nabumetone (Relafen) ☐ Etodolac (Lodine)

☐ Diclofenac (Voltaren/Cataflam) ☐ Celecoxib (Celebrex)

☐ Oral Steroids (Prednisone/Medrol Dose Pak)

☐ Opioid (narcotic) medications

☐ Tramadol (Ultram) ☐ Tylenol with Codeine (Tylenol 3)

☐ Hydrocodone (Vicodin/Lortab/Norco) ☐ Oxycodone (Percocet/Roxicet)

☐ Oxycodone ER (OxyContin) ☐ Oxymorphone (Opana)

☐ Morphine ☐ Tapentadol (Nucynta) ☐ Fentanyl Patches (Duragesic)

☐ Other: _____

☐ Nerve pain medications

☐ Gabapentin (Neurontin) ☐ Pregabalin (Lyrica) ☐ Amitriptylene (Elavil)

☐ Nortriptylene (Pamelor) ☐ Duloxetine (Cymbalta)

☐ Milnacipran (Savella) ☐ Venlafaxine (Effexor)

☐ Muscle Relaxants

☐ Cyclobenzaprine (Flexeril/Amrix) ☐ Metaxalone (Skelaxin)

☐ Methocarbamol (Robaxin) ☐ Orphenadrine (Norflex)

☐ Carisoprodol (Soma) ☐ Chlorzoxazone (Parafon Forte) ☐ Baclofen

☐ Topical treatments

☐ Menthol based over-the-counter topical ☐ Lidoderm patches

☐ Voltaren Gel ☐ Pennsaid Gel ☐ Flector Patches

☐ Other:_____

What injections have you had for this problem or the same problem in the past?

☐ Epidural ☐ SI joint ☐ Facet joint ☐ Hip ☐ Shoulder ☐ Knee ☐ Trigger point

☐ Occipital nerve ☐ Other injection . Explain:_____

Who performed the injection(s)_____ When?_____

Did it help?_____

What other treatments have you undergone for THIS problem? (please check all that apply)

☐ I have had no treatment for this problem

☐ Heat ☐ Ice

☐ Physical therapy (When: _____ Was it helpful? _____)

☐ Traction (When: _____ Was it helpful? _____)

☐ TENS unit (When: _____ Was it helpful? _____)

☐ Massage Therapy (When: _____ Was it helpful? _____)

☐ Chiropractor (When: _____ Was it helpful? _____)

☐ Bracing (Type of brace: _____ Was it helpful? _____)

☐ Other_____(When: _____ Was it helpful? _____)

Past Medical History

PAST MEDICAL HISTORY: (Please list all of your medical problems, past and present. For example: diabetes, high blood pressure, high cholesterol, asthma, blood clots, stroke, heart attack)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

PAST SURGICAL HISTORY: (please list all surgeries and dates)

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

ALLERGIES:

Do you have any Allergies to any Medications? ☐ Yes ☐ No (If yes, please list allergies)

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

Please also check the appropriate boxes if you are allergic to any of the following medications:

☐ Betadine/Iodine ☐ Lidocaine/Marcaine ☐ IV Contrast/Dye

☐ Cortisone (Steroids) ☐ Latex

Medication

ALL CURRENT MEDICATIONS: (name of medication, dose, and how often you take it)

1. _____ 8. _____
2. _____ 9. _____
3. _____ 10. _____
4. _____ 11. _____
5. _____ 12. _____
6. _____ 13. _____
7. _____ 14. _____

If you take any of the following blood thinning medications, please check the appropriate boxes:

☐ Coumadin (warfarin) ☐ Plavix ☐ Aspirin ☐ Aggrenox ☐ Ticlid

Family History

Please list medical problems that run in the family and the person's relationship to you:

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

Social History

Do you smoke? ☐ Yes ☐ No

** If YES, how many packs per day? ____ How many years have you smoked?_____

** If you smoked in the past, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If YES, how many drinks per week? _____

Have you ever been addicted to narcotic medications? ☐ Yes ☐ No

Do you have a regular exercise program? ☐ Yes ☐ No

** If YES, what do you do? _____How often? _____

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant other

Describe your living situation: ☐ Single Level Residence ☐ Multilevel Residence

Please check the appropriate boxes if you use any of the following: ☐ Cane ☐ Walker

☐ Manual Wheelchair ☐ Power Wheelchair ☐ Other _____

Occupational History

Are you currently working? ☐ Yes ☐ No Occupation:_____

Who is your employer?_____How long have you worked there?_____

How much weight do you regularly lift at your job?

☐ >100lbs ☐ 50-100 lbs ☐ 20-50 lbs ☐ 10-20 lbs ☐ <10 lbs

If not working, where and when did you last work?_____

System Review

REVIEW OF SYSTEMS: Please check the boxes if you experience any of the following:

CONS: ☐ Fevers/Chills ☐ Night Sweats ☐ Weight Loss ☐ Insomnia ☐ Fatigue

ENT: ☐ Hearing loss ☐ Wear Glasses/contacts ☐ Blurry vision ☐ Dry eyes/mouth

CARD: ☐ Chest pain ☐ Irregular heart rhythm ☐ Murmur ☐ Leg swelling (edema)

RESP: ☐ Shortness of breath ☐ Wheezing ☐ Cough ☐ Sputum/mucus

GI: ☐ Stomach ulcers ☐ Heartburn/reflux ☐ Diarrhea ☐ Constipation
☐ Blood in stools ☐ Black stools

GU: ☐ Blood in urine ☐ Painful urination ☐ Difficulty emptying bladder
☐ Nighttime urination (more than 2 times per night) ☐ Urgency to urinate

NEUR: ☐ Headaches ☐ Blackouts ☐ Dizziness ☐ Double vision ☐ Seizures

ENDO: ☐ Diabetes Mellitus ☐ Excessive thirst ☐ Heat/cold intolerance

HEME: ☐ Abnormal bleeding ☐ Anemia ☐ Previous transfusions

SKIN: ☐ Rashes ☐ Easy bruising ☐ Itching ☐ Hair or nail changes

PSYC: ☐ Depression ☐ Anxiety ☐ Mood Swings ☐ High stress level

OTHER: _____

_____

_____

_____

_____

_____

Patient Signature Date Provider Signature Date

Thank you for completing this form. We look forward to meeting you.

-The Rehab Doctors

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