MR#: _____

PHYSICAL MEDICINE & REHABILITATION
New Patient Health History Form

** Please Request Pertinent Medical Records from You Referring Doctor*

***Note:** failure to complete this form prior to your appointment may delay your appointment*

Date: _____/_____/_____ Age: _____

Patient Name: _____ Date of Birth: _____/_____/_____

Social Security #: _____-_____-_____ Birth Place: _____

Home Phone: (_____)_____-_____ Cell/Wk. Phone: (_____)_____-_____

Address: _____

City : _____ State: _____ Zip: _____

Email: _____

Primary Pharmacy: _____ Pharmacy Street/Location: _____

Referring Physician: _____ Primary Care Provider: _____

Accompanied By: ☐ Permission to discuss care in front of the above person.

REASON FOR TODAY'S VISIT: _____

Date when the symptoms began (approximate): _____

How Long Do The Symptoms Last? _____

Did your symptoms first occur ☐ gradually or ☐ suddenly, please explain: _____

_____

Are your symptoms due to an injury at work? ☐ No ☐ Yes, please explain: _____

_____

Are your symptoms due to a vehicle accident? ☐ No ☐ Yes, please explain: _____

_____

Is there any litigation (lawsuit)? ☐ No ☐ Yes, please explain: _____

PAIN ASSESSMENT:

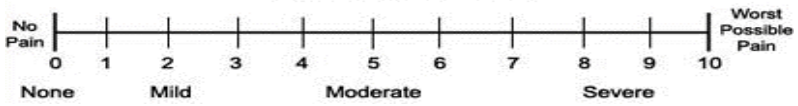
Where is your Pain? _____

_____

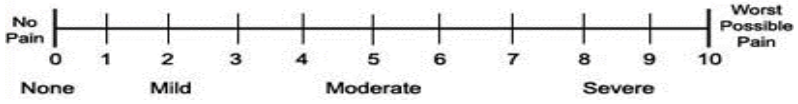
What type of pain is it? ☐ Constant ☐ Intermittent ☐ Sharp ☐Aching ☐Burning ☐ Dull

(Check up to 4) ☐ Tingling ☐ Numbness ☐ Spasms ☐ Electric ☐ Stabbing ☐ Cramping

Rate your pain today ?
(Circle One)



Rate your weekly average pain?
(Circle One)



When is the pain worse? ☐ Day ☐Night Does the pain awaken you? ☐ Yes ☐ No

Does the pain interfere with daily activities? ☐ Never ☐ Sometimes ☐ Mostly ☐ Always

If you have **BACK** and **LEG** pain, which best describes the ration between your **BACK** and **LEG** pain?

☐ 100% **BACK** pain & 0% **LEG** pain ☐ 75% **BACK** pain & 25% **LEG** pain ☐ 50% **BACK** pain & 50% **LEG** pain

☐ 25% **BACK** pain & 75% **LEG** pain ☐ 0% **BACK** pain & 100% **LEG** pain

If you have **NECK** and **ARM** pain, which best describes the ration between your **NECK** and **ARM** pain?

☐ 100% **NECK** pain & 0% **ARM** pain ☐ 75% **NECK** pain & 25% **ARM** pain ☐ 50% **NECK** pain & 50% **ARM** pain

☐ 25% **NECK** pain & 75% **ARM** pain ☐ 0% **NECK** pain & 100% **ARM** pain

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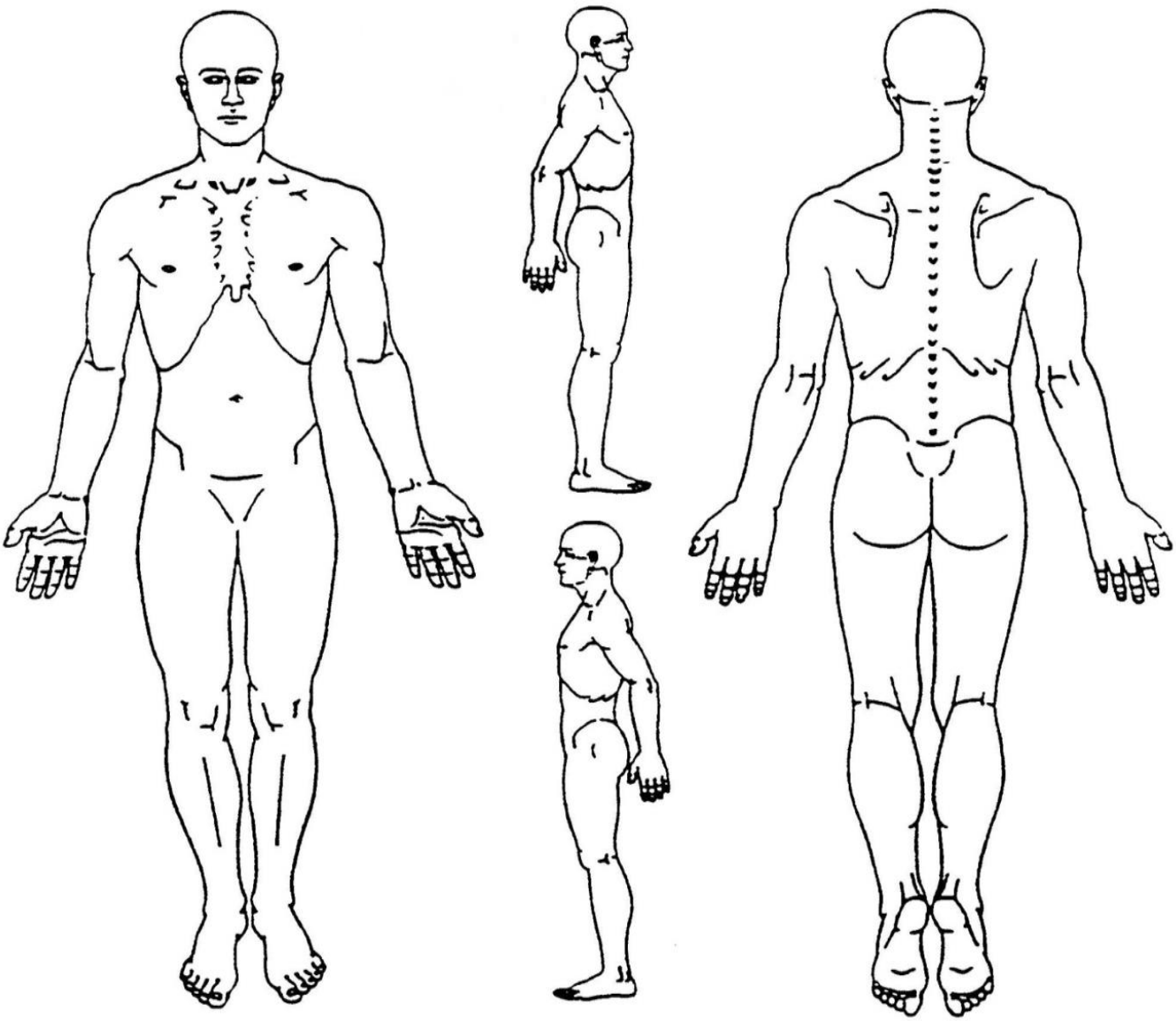
*Indicate what position/activity aggravates or relieves the pain by placing an **'X'** in the box.*

	Aggravated by	***Relieved by***		***Aggravated by***	***Relieved by***		***Aggravated by***	***Relieved by***
Bending back	☐	☐	Exercise	☐	☐	Sitting	☐	☐
Bending forward	☐	☐	Fetal position	☐	☐	Stretching	☐	☐
Climbing stairs	☐	☐	Heat	☐	☐	Driving	☐	☐
Coughing	☐	☐	Injection	☐	☐	Standing	☐	☐
Bowel movement	☐	☐	Lying down	☐	☐	Pushing	☐	☐
Lifting	☐	☐	Alcohol	☐	☐	Walking	☐	☐
Looking down	☐	☐	OTC Medication	☐	☐	Walking down hill	☐	☐
Looking up	☐	☐	Rest	☐	☐	Walking up hill	☐	☐
Turning head	☐	☐	Ice	☐	☐	Using a shopping Cart	☐	☐
Pulling	☐	☐	Massage	☐	☐	Other: _____	☐	☐

Pain Diagram: Use the key to indicate areas affected by pain: **X** = Burning **0** = Numbness **/** = Aching **+** = Pins / Needles



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PHYSICAL MEDICINE & REHABILITATION: New Patient Health History Form

SYSTEM REVIEW: *Place an 'X' in the No or Yes columns, if currently suffer from any of the following symptoms.*

No	Yes	Constitutional	No	Yes	Cardiovascular	No	Yes	Metabolic/Endocrine	No	Yes	Integumentary
		Chills			Chest Pain			Cold Intolerance			Contact Allergy
		Fatigue			Leg Swelling			Heat Intolerance			Itchy Skin
		Fever			Fainting			Excessive Thirst			Rash
		General Discomfort			Irregular Heartbeat			Hair Loss			Skin Infections
		Night Sweats			Palpitations						Skin Lesion(S)
		Weight Gain			Varicose Veins						Nail Changes
		Weight Loss									
		Lethargy									

No	Yes	HEENT	No	Yes	Gastrointestinal	No	Yes	Neurological	No	Yes	Musculoskeletal
		Blurred Vision			Abdominal Pain			Difficulty Walking			Back Pain
		Double Vision			Constipation			Dizziness			Neck Stiffness
		Difficulty Swallowing			Diarrhea			Poor Coordination			Bone/Joint Symptoms
		Facial Pain			Heartburn/Reflux			Memory Loss			Muscle Weakness
		Headache			Loss Of Appetite			Muscle Weakness			Broken Bones/Fractures
		Ringing In Ears			Nausea			Tingling/Pricking			
					Vomiting			Seizures			
					Change In Bowl Habits			Tremors	No	Yes	**Hematologic**
					Blood in Stool			Light-Headedness			Easy Bleeding
								Migraines			Easy Bruising

No	Yes	Respiratory	No	Yes	Genitourinary	No	Yes	Psychiatric	No	Yes	Immunological
		Cough			Dysuria			Anxiety			Asthma
		Asthma			Frequent Urination			Depression			Environmental Allergies
		Recent Infections			Urinary Incontinence			Insomnia			
		TB Exposure			Change In Bladder Habits						
		Wheezing			Decrease Urine Stream						
		Emphysema			Decrease Urine Output						

MEDICAL HISTORY: *Place a Check in the box next to the following conditions you have been diagnosed with.*

☐ Alzheimer's disease	☐ Depression	☐ Hyperlipidemia	☐ Renal Disease
☐ Anemia	☐ Diabetes	☐ Hypertension	☐ Rheumatoid Arthritis
☐ Angina	☐ Drug Abuse	☐ Irritable Bowel	☐ Scoliosis
☐ Arthritis	☐ Elevated Lipids	☐ Lyme Disease	☐ Seizure Disorder
☐ Arrhythmia	☐ Epilepsy	☐ Myocardial Infarction	☐ Sleep Apnea
☐ Anxiety	☐ Fibromyalgia	☐ Obesity	☐ Spinal Stenosis
☐ Asthma	☐ Fracture	☐ Osteoarthritis	☐ Spinal Cord Injury
☐ Bursitis	☐ Gout	☐ Osteoporosis	☐ Spondyloarthropathy
☐ Congestive Heart Failure	☐ Glaucoma	☐ Parkinson Disease	☐ Stroke
☐ COPD	☐ Headache/Migraines	☐ Peptic Ulcer Disease	☐ Systemic Lupus
☐ Coronary Artery Disease	☐ Headache, Tension	☐ Peripheral Nerve Disease	☐ Thyroid Disorder
☐ Crohn's Disease	☐ Heart Disease	☐ Post-Traumatic Stress	☐ Tuberculosis (TB)
☐ Deep Venous Thrombosis	☐ Hepatitis C	☐ Psychiatric Disorders	
☐ Degenerative Joint Disease	☐ HIV/AIDS		

☐ Other: _____

Women Only: Are you pregnant? ☐ No ☐ Yes if Yes _____ weeks pregnant Nursing? ☐ No ☐ Yes

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PHYSICAL MEDICINE & REHABILITATION: New Patient Health History Form

TREATMENTS: *Place a Check in the box next to the following treatments you have tried.*

Treatments	*Did it Help?*	*Date(s)*	*Physician*	*Details*
☐ Pain Clinic/Anesthesiologist:	☐ Yes ☐ No			
☐ Trigger Point Injections:	☐ Yes ☐ No			
☐ Biofeedback/Relaxation:	☐ Yes ☐ No			
☐ TENS Unit:	☐ Yes ☐ No			
☐ Counseling:	☐ Yes ☐ No			
☐ Acupuncture:	☐ Yes ☐ No			
☐ Home Exercise Program:	☐ Yes ☐ No			
☐ Epidural Steroid Injections:	☐ Yes ☐ No			
☐ Other:_____	☐ Yes ☐ No			

PHYSICAL THERAPY:

Have you had **Physical Therapy**? ☐ No ☐ Yes, where? _____

What helped? _____

What did **NOT** Help? _____

What Percentage of improvement did you have overall with therapy? _____% (1-100)

DIAGNOSTIC HISTORY: *Place a Check in the box next to the testing that apply.*

Test	*Body Part*	*Date*	*Facility*
☐ Last MRI:			
☐ Last CT:			
☐ EMG/Nerve Study:			
☐ X-Rays:			
☐ Other:_____			

SURGICAL HISTORY: *Place a Check in the box next to the following surgeries you have had and indicate left/right or both sides.*

Surgery		*Physician*	*Date*	*Surgery*		*Physician*	*Date*
☐ AC Joint Repair	**L R**			☐ Hip Replacement	**L R**		
☐ Amputation	**L R**			☐ Hysterectomy			
☐ Angioplasty	**L R**			☐ Hand	**L R**		
☐ Appendectomy	**L R**			☐ Knee Replacement	**L R**		
☐ Back Surgery				☐ Mastectomy	**L R**		
☐ Cardiac Pacemaker	**L R**			☐ Shoulder	**L R**		
☐ Carpal Tunnel	**L R**			☐ Rotator cuff Repair	**L R**		
☐ C-Section				☐ Intestinal Resection			
☐ Colostomy	**L R**			☐ Tonsillectomy			
☐ Hernia Repair	**L R**			☐ Wrist	**L R**		
☐ Kidney	**L R**			☐ Thyroid	**L R**		
☐ Bladder	**L R**			☐ Ulcer	**L R**		
☐ Foot	**L R**			☐ Pain Pump(s)			
☐ Neck Surgery				☐ Spinal Cord Stimulator			
☐ Other:_____	**L R**			☐ Other:_____	**L R**		

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FAMILY HISTORY: *Circle the letter that represents the family member: Mother (M), Father (F), Sister (S), Brother (B)*

Father: ☐ Alive & Well Age:_____ ☐ Deceased, Cause of Death:_____ Age:_____

Mother: ☐ Alive & Well Age:_____ ☐ Deceased, Cause of Death:_____ Age: _____

ADD/ADHD	M	F	S	B	COPD	M	F	S	B	Muscle Disease:_____	M	F	S	B
Alcoholism	M	F	S	B	Coronary Artery Disease	M	F	S	B	Muscular Dystrophy	M	F	S	B
Allergies	M	F	S	B	Depression	M	F	S	B	Multiple Sclerosis	M	F	S	B
Alzheimer's disease	M	F	S	B	Diabetes *Type*:_____	M	F	S	B	Obesity	M	F	S	B
Arthritis:_____	M	F	S	B	Drug Abuse	M	F	S	B	Osteoporosis	M	F	S	B
Asthma	M	F	S	B	Fibromyalgia	M	F	S	B	Parkinson's	M	F	S	B
Blood disorder	M	F	S	B	Hypertension	M	F	S	B	Peripheral Vascular Disease	M	F	S	B
Cancer *Type*:_____	M	F	S	B	Hyperlipidemia	M	F	S	B	Renal Disorder	M	F	S	B
Cardiovascular Disease:_____	M	F	S	B	Irritable bowel disease	M	F	S	B	Seizure Disorder	M	F	S	B
Colitis	M	F	S	B	Liver Disease *Stage*:_____	M	F	S	B	Spinal Cord Injury	M	F	S	B
Congenital Heart Disease	M	F	S	B	Mental Illness *Type*:_____	M	F	S	B	Stroke	M	F	S	B
Congenital Heart Failure	M	F	S	B	Migraines	M	F	S	B	Thyroid Disorder	M	F	S	B

SOCIAL HISTORY:

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children: ☐ Boy(s) #_____ ☐ Girl(s) #_____

Education: *circle highest level attended*
Grade School: 7 8 9 10 11 12 **College:** 1 2 3 4 **Degree(s):** _____

Work: Occupation: _____ ☐ Part-time ☐ Full-time - Average # of hours work per week: ___
Describe the physical demands of your job: _____
☐ Retired, Age at Retirement:_____ ☐ Disabled, Age at Disability:_____

Tobacco: Do you use tobacco? ☐ No/Never ☐ Yes ☐ Former - How long ago? _____ Age Quit:_____
Tobacco Type: ☐ Cigarette ☐ Cigarillo ☐ Cigar ☐ Pipe ☐ Chew ☐ Smokeless ☐ Snuff ☐ Vape
Smoker Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Heavy smoke ☐ Light smoker

Caffeine: Do you drink caffeinated beverages ☐ No ☐ Yes, what type: _____ Cups per day: _____

Alcohol: Do you drink alcohol? ☐ No ☐ Yes, what type of alcohol?_____ Amount:_____
Frequency: ☐ daily ☐ weekly ☐ monthly ☐ socially ☐ occasionally ☐ rarely
Has anyone ever told you to cut down on drinking? ☐ No ☐ Yes

Drugs: Do you use drugs for any reasons that are not medical? ☐ No ☐ Yes, please list:_____

Sleep Patterns: How many hours of sleep do you get at night?_____ Trouble falling asleep? ☐ No ☐ Yes
Difficultly staying asleep? ☐ No ☐ Yes Do you wake up frequently? ☐ No ☐ Yes

Travel History: Have you traveled outside the USA? ☐ No ☐ Yes , where/when?_____

Lifestyle: Do you exercise regularly? ☐ No ☐ Yes, Type of exercise:_____ Gym Membership: ☐ No ☐ Yes
Level of Activity: ☐ Sedentary ☐ Moderate ☐ Vigorous

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Allergies to Medications: *List any allergies or intolerances to medications & include your reaction*

Medication Allergy	Reaction(s)

Are you allergic to Contrast Dye? ☐ No ☐ Yes If yes, what happens? _____

Are you allergic to IODINE? ☐ No ☐ Yes If yes, what happens? _____

PRESENT MEDICATIONS: *List all medications you are taking, Include: aspirin, vitamins, laxatives, herbal supplements, & etc.*

Name of Medication	Dose *(Strength & Pills Per Day)*	Prescribing Doctor & Date	Does it Help? Yes	**Some**	No
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐
11.			☐	☐	☐
12.			☐	☐	☐
13.			☐	☐	☐
14.			☐	☐	☐
15.			☐	☐	☐
16.			☐	☐	☐
17.			☐	☐	☐
18.			☐	☐	☐
19.			☐	☐	☐
20.			☐	☐	☐
21.			☐	☐	☐
22.			☐	☐	☐
23.			☐	☐	☐
24.			☐	☐	☐
25			☐	☐	☐

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