Patient Name: _____ *Follow Up Medical History Intake Form*

Date of Birth: ____/____/____ **Age: ____** **Today's Date____/____/____**

MR#: **Referred By:_____**

CC: **What problem/issue brings you here today?**

HPI: **Since your last physician visit, are your symptoms …**					Better		Worse		Same	
If better, by how much on a scale of 0-100%? (if 0 was the way you were and 100% was completely normal)										%
What makes it *worse*?	walking	sitting	standing	lying down	nothing	exercise	Other:			
What makes it *better*?	walking	sitting	standing	lying down	nothing	exercise	Other:			
What do you want to accomplish from today's visit?	Diagnosis	Treatment Options	X-ray Rx	MRI Rx	Med Rx	Review Test	Injection Rx			
If currently in physical therapy / chiropractic, about how many visits have you had?	N/A									
If you had an injection since last visit, was it helpful?	N/A	No	Yes	Yes, but only for ____ days / weeks / months						

Please make a *mark on the line* below to indicate the level of discomfort you have today.

No Pain ——————————————— Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

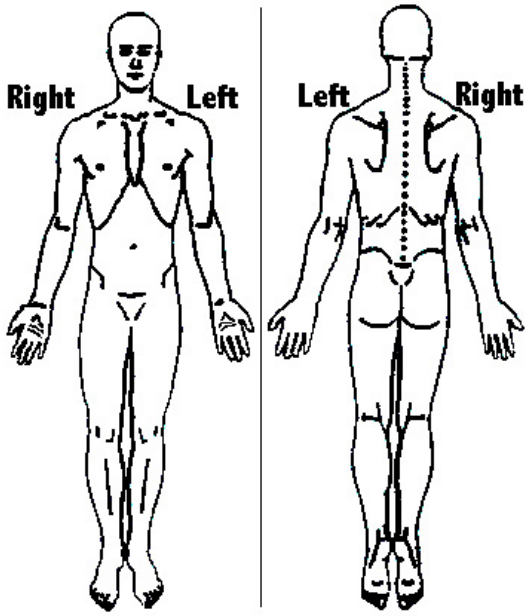
Please describe what the pain feels like: Dull, Achy, Burning, Stabbing, Numbness, Tingling, Pulling, Cramping, Tight, Stiff

Please describe the time course of your pain: Constant, Comes and goes, Getting worse, Getting better, Staying about the same

***Medications* (Current):**

ALL medications including Prescription, Over-the-Counter (ie Advil), Supplements, Vitamins

Please draw where you have Pain



Medical/Surgical History: **Any *New Medical* problems**, ***Surgeries***, or **medication *Allergies*** since your last physician visit?	No	Yes
Family History: **Any *New Family* medical problems** since your last physician visit?	No	Yes

Social History:

What do you do for exercise?

Tobacco use (cigarette, cigar, pipe, chew)**:**	Current	Quit	Never

Number of alcoholic beverages per week?

Occupation:

Employment status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent	Not working	Retired

Review of Systems

Night pain, fevers, unintentional weight change?	Yes	No
Vision change, double vision?	Yes	No
Difficulty swallowing, headaches?	Yes	No
Chest pain, palpitations?	Yes	No
Shortness of breath, wheezing, cough after exercise?	Yes	No
Nausea, vomiting, black stools, loss of control of stools?	Yes	No
Loss of control of urine, urinary frequency or urgency?	Yes	No
New rashes or psoriasis?	Yes	No
Dizziness, weakness, numbness, tingling?	Yes	No
Depressed mood, sleep problems, anxiety?	Yes	No
Current low back pain, other joint swelling or muscle pain?	Yes	No
♀ **Are you pregnant, trying to get pregnant or breastfeeding?**	Yes	No
♀ **Last menstrual period date:** **Periods regular?**	Yes	No

Patient's Signature:_____

Physician Initials/Date/Time: ____/____/____

Pain Disability Index

Patient Name: _____ MRN: Date:____/____/_____

Date of Birth: ___/____/____

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. Please select the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK.

A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply.

FAMILY/HOME RESPONSIBILITIES: This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g., yard work, house cleaning) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10

No Disability Mild Moderate Severe Total Disability

RECREATION: This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

No Disability Mild Moderate Severe Total Disability

SOCIAL ACTIVITY: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

No Disability Mild Moderate Severe Total Disability

OCCUPATION: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as housewife or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

No Disability Mild Moderate Severe Total Disability

SEXUAL BEHAVIOR: This category refers to the frequency and quality of one's sex life.

0 1 2 3 4 5 6 7 8 9 10

No Disability Mild Moderate Severe Total Disability

SELF-CARE: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed).

0 1 2 3 4 5 6 7 8 9 10

No Disability Mild Moderate Severe Total Disability

LIFE-SUPPORT ACTIVITY: This category refers to basic life-supporting behaviors such as eating and sleeping.

0 1 2 3 4 5 6 7 8 9 10

No Disability Mild Moderate Severe Total Disability

Patient Specific Functional Scale

Identify the most important activity that you are unable to do or are having difficulty with as a result of your current problem. Today, what activity are you unable to do or having difficulty with because of your current problem?_____

(examples may include things like, "sitting for 1 hour", "standing for 1 hour", "picking up my child", "running for 30 minutes", "walking for 1 block".)

*Please rate your ability to perform this functional activity now:

0 1 2 3 4 5 6 7 8 9 10

Unable to perform **Able to perform at prior level**

***** Note that this scale is rated on your ABILITY to do the activity – so it is reverse from the questions above