Initial Medical History Intake Form

Patient Name: _____
Date of Birth: ____/____/____
MR#:

Today's Date____/____/____
Referred by:_____

Where do you have pain or a problem (which body part)?

Does the pain travel or radiate?	Yes	No	

How long have you had this problem? ____ weeks / months / years

Onset on pain?	gradual	sudden				
What makes it *worse*?	walking	sitting	standing	lying down	exercise	Other:

Please describe what the pain feels like:

Dull, Achy, Burning, Stabbing, Numbness, Tingling, Pulling, Cramping, Stiff, Tight, Sharp

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

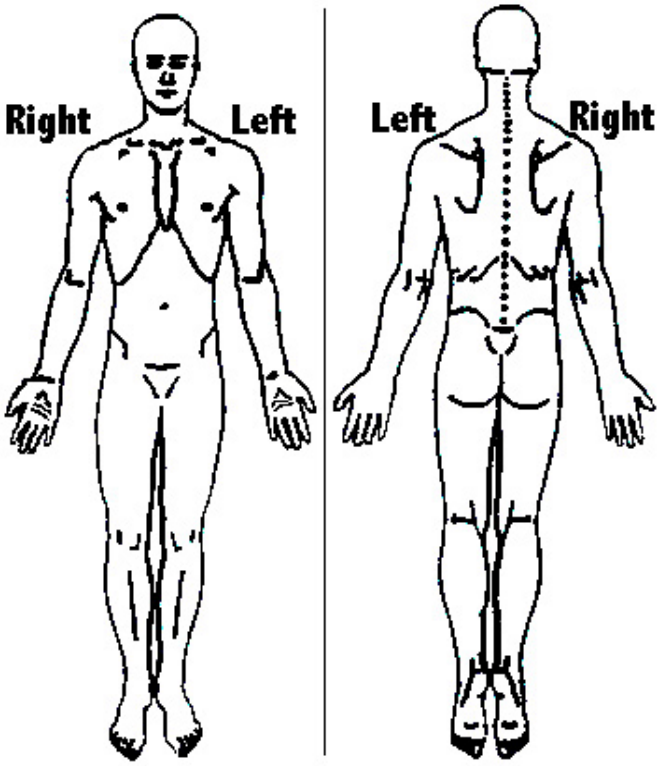
No Pain _____ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Review of Systems

Fevers?	Yes	No
Unintentional weight loss?	Yes	No
Vision change?	Yes	No
Headaches?	Yes	No
Chest pain?	Yes	No
Shortness of breath?	Yes	No
Loss of control of stools?	Yes	No
Loss of control of urine?	Yes	No
New rashes?	Yes	No
Weakness?	Yes	No
Numbness, tingling?	Yes	No
Depressed mood?	Yes	No
Sleep problems?	Yes	No
Anxiety?	Yes	No
Other joint swelling?	Yes	No
♀ **Are you pregnant, trying to get pregnant or breastfeeding?**	Yes	No

Please draw where you have Pain



Patient's Signature:_____

Physician Initials Date/Time: ____/____/____ ___:___ am/pm

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM | HOSPITAL of the UNIVERSITY of PENNSYLVANIA

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

Office Use Scoring: Sum Total: ____/70