CONFIDENTIAL

Name:_____ Date:_____

SMOKING STATUS: Never Social Everyday Interested in Quiting Former

CANCER: None Breast Colon Ovarian Prostate Skin Other:_____

BROKEN BONES: None R / L:_____ R / L:_____
R / L:_____ R / L:_____

NEURO: None Paralysis Muscle Weakness Loss of Sensation Seizures Difficulty Reading Writing Lost of Memory Unexplained Pain Decreased Alertness
R L B
_____

CONDITIONS: Anxiety Disc Diabetes Bruising Dizziness Fibro-myalgia Asthma ♥ Attack Stroke Heartburn Osteo-penia Ear Ringing Osteo-porosis Loss of smell AS MS Taste Loss Tumor Thyroid
other or None C T L Stenosis Scoliosis
_____ Auto/job injuries + when?_____

SURGERIES: None C-Section Joint Replaced Broken Bone Angio-plasty Stent Hyster-ectomy Gall Bladder ♥ Bypass
other:_____
_____ R L B R L B
_____ _____ _____ minors cane walker wheelchair
_____ R L B R L B
_____ _____ _____ Are you at risk for falls? YES or NO
taking benzodiazepines

MEDICATIONS: _____
None
Medication Allergies: None or _____
Do you exercise?_____ Drink alcohol?_____ If pregnant, Due Date:_____
Significant Family HISTORY Please fill in blanks below or Adopted
MOTHER: _____
FATHER: _____
SIBLINGS: _____
CHILDREN: _____

Over the last 2 wks, how often have you been bothered by any of the following problems? Mark below:

	Not at all	Some	Most Days	Everyday
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping to much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
Trouble concentrating on things				
Moving or speaking so slowly or being so fidgety or restless				
Thoughts that you would be better off dead or hurt yourself				

I have disclosed all significant health conditions to the best of my knowledge and will update Dr Jill asap.

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Patient Name:_____ Pt #:_____

Vitals: Height_____ Weight_____ Blood Pressure / Pulse_____

For each activity mark the response if you had to do it TODAY: CASH payer – skip to Complaint #1

	Not difficult	Minimally	Somewhat	Fairly	Very	Unable to do
Turn over in bed	O	O	O	O	O	O
Sleep through the night	O	O	O	O	O	O
Get out of bed	O	O	O	O	O	O
Make your bed	O	O	O	O	O	O
Put on socks	O	O	O	O	O	O
Stand up for 20-30 minutes	O	O	O	O	O	O
Take food out of the fridge	O	O	O	O	O	O
Reach up to high shelves	O	O	O	O	O	O
Move a chair	O	O	O	O	O	O
Sit in a chair for couple hours	O	O	O	O	O	O
Ride in a car	O	O	O	O	O	O
Carry 2 bags of groceries	O	O	O	O	O	O
Walk a few blocks	O	O	O	O	O	O
Walk a few miles	O	O	O	O	O	O
Climb one flight of stairs	O	O	O	O	O	O
Bend over to clean bathtub	O	O	O	O	O	O
Pull or push heavy doors	O	O	O	O	O	O
Throw a ball	O	O	O	O	O	O
Lift a heavy suitcase	O	O	O	O	O	O
Run one block	O	O	O	O	O	O

Complaint # 1:_____

With 10 being the worst pain, please circle the number that best describes the symptom?

1 2 3 4 5 6 7 8 9 10

What percentage of the day do you experience the symptom at the above pain level?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Is the symptom worse at certain times? Morning Afternoon Evening Night Unaffected

When did the symptom begin?_____ How?_____

Symptom quality? Sharp Dull Achy Burn Throb Stab Deep Nag Sting Shoot_____

What makes the symtom worse? Bend Tilt Turn Twist Sit Stand Rise Out of Chair Lift Drive Walk Run Family Care Grocery Shop Household Chores Computer Yardwork Other_____

What makes the symptom better? Rest Ice Heat Stretch Exercise Massage Meds

Patient Signature:_____ Date:_____

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Patient Name:_____ Pt #:_____

Complaint # 2:_____

With 10 being the worst pain, please circle the number that best describes the symptom?

1 2 3 4 5 6 7 8 9 10

What percentage of the day do you experience the symptom at the above pain level?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____ How?_____

What makes the symtom worse? Bend Tilt Turn Twist Sit Stand Rise Out of Chair Lift Drive

Walk Run Family Care Grocery Shop Household Chores Computer Yardwork Other_____

What makes the symptom better? Rest Ice Heat Stretch Exercise Massage Meds

Symptom quality? Sharp Dull Achy Burn Throb Stab Deep Nag Sting Shoot_____

Is the symptom worse at certain times? Morning Afternoon Evening Night Unaffected

Complaint # 3:_____

With 10 being the worst pain, please circle the number that best describes the symptom?

1 2 3 4 5 6 7 8 9 10

What percentage of the day do you experience the symptom at the above pain level?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____ How?_____

What makes the symtom worse? Bend Tilt Turn Twist Sit Stand Rise Out of Chair Lift Drive

Walk Run Family Care Grocery Shop Household Chores Computer Yardwork Other_____

What makes the symptom better? Rest Ice Heat Stretch Exercise Massage Meds

Symptom quality? Sharp Dull Achy Burn Throb Stab Deep Nag Sting Shoot_____

Is the symptom worse at certain times? Morning Afternoon Evening Night Unaffected

Insurance companies will consider paying for care that helps you FUNCTION better;
if you cannot answer the above questions, YOU will be responsible for all charges.

Patient Signature:_____ Date:_____

CONFIDENTIAL

Patient Name:_____ Pt #:_____

Complaint # 4:_____

With 10 being the worst pain, please circle the number that best describes the symptom?

1 2 3 4 5 6 7 8 9 10

What percentage of the day do you experience the symptom at the above pain level?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____ How?_____

What makes the symtom worse? Bend Tilt Turn Twist Sit Stand Rise Out of Chair Lift Drive

Walk Run Family Care Grocery Shop Household Chores Computer Yardwork Other_____

What makes the symptom better? Rest Ice Heat Stretch Exercise Massage Meds

Symptom quality? Sharp Dull Achy Burn Throb Stab Deep Nag Sting Shoot_____

Is the symptom worse at certain times? Morning Afternoon Evening Night Unaffected

Complaint # 5:_____

With 10 being the worst pain, please circle the number that best describes the symptom?

1 2 3 4 5 6 7 8 9 10

What percentage of the day do you experience the symptom at the above pain level?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____ How?_____

What makes the symtom worse? Bend Tilt Turn Twist Sit Stand Rise Out of Chair Lift Drive

Walk Run Family Care Grocery Shop Household Chores Computer Yardwork Other_____

What makes the symptom better? Rest Ice Heat Stretch Exercise Massage Meds

Symptom quality? Sharp Dull Achy Burn Throb Stab Deep Nag Sting Shoot_____

Is the symptom worse at certain times? Morning Afternoon Evening Night Unaffected

Insurance companies will consider paying for care that helps you FUNCTION better;
if you cannot answer the above questions, YOU will be responsible for all charges.

Patient Signature:_____ Date:_____