CONFIDENTIAL

Name:_____ Date:_____

SMOKING STATUS: Never Social Everyday Former ALCOHOL: Yes No

CANCER: None Breast Prostate Lung Colon Bladder Skin Thyroid Other

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

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

Anxiety Asthma Apnea COPD Depression Diabetes Heart Attack Obesity
CONDITIONS: Disc Dizziness Fibro- Osteo- Osteo- AS Stroke Tumor
None Stenosis Ear Ringing myalgia penia porosis MS Scoliosis Poor Posture
C T L _____ If Pregnant, Due Date:_____

SURGERIES: None Jt Replaced Appendix Angioplasty Biopsy Cataract C-Section Hyster- Gall
_____ R L B _____ Heart Stent ectomy Bladder
_____ _____ Broken Cane _____ Bypass
_____ R L B Bone Walker Are you at risk for falls? YES or NO
_____ _____ Repair Wheelchair taking benzodiazepines

MEDICATIONS: _____
None Blood Pressure Cholesterol BCP M Relaxer Anxiety Depression Diuretic

Medication Allergies: None or _____

List Health Conditions of Family Members: No Conditions Adopted Unknown
MOTHER: _____
FATHER: _____
SIBLINGS: _____
CHILDREN: _____

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

Opt Out_____	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 item, please circle the words which most closely describes your condition right now:

PAIN INTENSITY	No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible
SLEEPING	Perfect Sleep	Mild Disturbed	Moderate	Greatly	Total Disturbed
PERSONAL CARE	No Restriction	Mild Pain	Slow Care	Need Help	100% Help
TRAVEL	No Trouble	Mild Trouble	Moderate	Moderate	Severe Trouble
		Long Trips	Long Trips	Short Trips	Short Trips
WORK	Unlimited Extra	No Extra	50% Usual	25% Usual	Cannot Work
RECREATION	Do All Activities	Most Activities	Some Activities	Few Activities	No Activities
FREQUENCY OF PAIN	No Pain	25% of day	50% of day	75% of day	100% of day
LIFTING	No Pain	More Pain w	More Pain w	More Pain w	More Pain w
		Heavy Lifting	Moderate Wt	Light Weight	Any Weight
WALKING	Any Distance	More Pain	More Pain	More Pain	More Pain
		w 1 mile	w 1/2 mile	w 1/4 mile	w all walking
STANDING	No Pain	More Pain	More Pain	More Pain	More Pain
	Several Hrs	Several Hrs	After 1 Hour	After 1/2 Hour	Any Standing

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

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 it 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 it 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:_____