PLEASE FILL OUT THE FOLLOWING INFORMATION COMPLETELY

The Physiatry Medical Group

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Name:____________________________________ MR#______________________(Office Use) Date:___________________
DOB: _________________ Age:______________ Email:____
Referral: ☐Self ☐Physician: ____________________ ☐Physical Therapist: ___________________ ☐Other: ___________
What is your chief complaint? ___________________________________ Date of injury or onset of symptoms: _____________
Describe the injury or problem: ____

Instructions: Mark the drawings according to where you feel pain. (if the right side of your neck hurts, mark the drawing on the right side, ect. Please indicate which sensation you feel by using the key below.
☐RIGHT HANDED
☐LEFT HANDED

KEY
///// Stabbing
X X X X Burning
0 0 0 0 Pins & Needles
= = = = Numbness
+ + + + Aching

Right   Left   Right

Front   Back

Rate your pain

Please circle your pain level 0=no pain 10=Extreme pain

1. Right now: 0 1 2 3 4 5 6 7 8 9 10
2. At best: 0 1 2 3 4 5 6 7 8 9 10
3. At worst: 0 1 2 3 4 5 6 7 8 9 10

What makes the pain better?
(example: ice, heat, stretching, medication)

What makes the pain worse?
(example: prolong sitting, prolong standing, bending, twisting)

Pharmacy Name:_____________________________________ **City:**____
Cross Streets:_______________________________________ **Phone#(if known):** __________________________________

Primary Care Physician

Name: __________________________________ Address: ____
Phone: __________________________________ Fax: ____
☐ Please check here if you would like us to send copies of your notes to your primary care physician

Social History (please check all that apply)

Height: ______________ Weight: ____________ **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Work Status: ☐Full-Time ☐Part-Time ☐Not working ☐Student ☐Retired ☐Disability (start date:___/___/___)

Occupation (if working):________________________ City: _______________________ Company: ____________________

School (if full time student):______________________________ City: ____________________________ Grade:______

Please check any sports that apply: ☐Baseball/Softball ☐Basketball ☐Football ☐Golf ☐Gymnastics ☐Lacrosse
☐Running/track ☐Soccer ☐Swimming ☐Tennis ☐Volleyball ☐Weightlifting ☐Other:___________________

Tobacco Use: ☐Never ☐Former: When did you quit:_____________ ☐Current: How many per day?:____________

Alcohol Use: ☐None ☐Rare ☐Occasional ☐Moderate ☐Heavy

REVIEW OF SYSTEMS (PLEASE CIRCLE ALL THAT APPLY)

General: Anorexia Appetite Loss Chills Fatigue Fever Night Sweats Weight Loss > 10lbs

Skin: Bruising Hair Loss Nail Changes **Neck:** Neck Stiffness **Breast:** Breast Mass

HEENT: Headache Head Injury Blurred Vision Double Vision Visual Loss Sleep Apnea

Respiratory: Difficulty Breathing Difficulty Breathing on Exertion Wheezing

Cardiovascular: Hypertension Chest Pain Irregular Heart Beat Palpitations Swelling of Extremities

Gastrointestinal: Bloody Stool Constipation Incontinence of Stool Laxative Use

Female Genitourinary: Absence of Menstruation Amenorrhea Menorrhagia Menstrual Irregularities Stress Incontinence

Male Genitourinary: Blood in Urine Tactical Mass Urinary Retention or Incontinence

Musculoskeletal: Decreased Range of Motion Joint Pain Joint Stiffness

Neurological: Dizziness Headaches Loss of Consciousness Stroke **Endocrine:** Cold Intolerance Thyroid Problems

Psychiatric: Anxiety Depression Mood changes Trouble Falling Asleep **Hematology:** Anemia Blood Clots Easy Bruising

MAJOR MEDICAL (please circle any of the following that you have had/do have):

Asthma Bipolar disorder Breast cancer COPD(chronic obstructive pulmonary disease) Coronary artery disease Diabetes type 1 Diabetes type 2 GERD(gastro esophageal reflux disease) High cholesterol Hypertension Hypothyroid Major depression Osteoarthritis Prostate enlargement Prostate Cancer Rheumatoid arthritis ☐NONE

☐Any other major medical problems:____

ALLERGIES

(Please check any of the following that apply/use reverse page if needed):

●Do you have allergies to any medications: ☐Yes ☐ No ☐Unknown (If yes, please list medication and reaction below ie:rash, swelling, ect):

Medication:__________________ Reaction:__________________ Medication:____________________ Reaction:______________________

●Do you have an allergy to contrast dyes? ☐Yes ☐No ☐Unknown ●Do you take aspirin or any blood thinners daily? ☐Yes ☐No ☐Unknown

●Are you allergic to anything else we should be aware of (i.e. Shellfish, latex etc.):____

MEDICATIONS

Please list your medications below (if you need more space please use reverse page):

Medication	Strength/dose	Frequency

MAJOR SURGIERIES

Please check off any past surgeries you have had, the date/year procedure was done and by which doctor(if known):

☐Appendectomy______________ ☐Back Surgery_______________ ☐Breast Surgery____________ ☐Discectomy_____________
☐ Hip Fracture and Surgery (left or right)____________________ ☐Hysterectomy________________ ☐Laminectomy_____________
☐Microdiscectomy_______________ ☐Spinal Fusion______________ ☐Tonsillectomy____________ ☐Prostate Surgery__________
☐Other:____

Family History (Please put an "X" in each box that applies)

	M	F	B	S	MGM	MGF	PGM	PGF
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Thyroid								
Blood Clots								
Bleeding Disorders								
Multiple Sclerosis								
Rheumatoid Arthritis								
Osteoarthritis								
Osteoporosis								
Low Back Pain								
Respiratory Problems								
Anesthesia Complications								

KEY

F=Father
B=Brother
S=Sister
MGM=Maternal Grandmother
MGF=Maternal Grandfather
PGM= Paternal Grandmother
PGF= Paternal Grandfather

Have you had any of the follow tests or treatments for this problem?

TESTS	NO	YES	Dates	Ordering Doctor (If known)	Diagnosis/Outcome (If known)
• MRI	☐	☐	______	______	______
• C/T Scan	☐	☐	______	______	______
• X-ray	☐	☐	______	______	______
• EMG	☐	☐	______	______	______
• Ultra Sound	☐	☐	______	______	______
• Bone Scan	☐	☐	______	______	______
• Spinal Injections	☐	☐	______	______	______

TREATMENTS	NO	YES	Dates of Treatment	Was it helpful
• Physical Therapy	☐	☐	______	______
• Chiropractic Care	☐	☐	______	______
• Massage	☐	☐	______	______
• Acupuncture	☐	☐	______	______
• Pilates	☐	☐	______	______
• Yoga	☐	☐	______	______
• Home Exercise Program	☐	☐	______	______
• ROLFING	☐	☐	______	______

Are there any specific questions or concerns that you would like to discuss today?

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