

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Today's Date: ____ / ____ / ____

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (First) _____ (Middle) _____ (Last) _____
Address: _____ City: _____ State: _____
Zip: _____ Birth Date: ____ / ____ / ____ Age: ____
Marital Status (Circle): Divorced Married Single Separated Widowed
Gender (Circle): Male / Female Home Phone: (____) _____ - _____
Cell Phone: (____) _____ - _____ Cell Phone Carrier _____
Email Address: _____ @ _____

Emergency Contact Information

Name: (First) _____ (Last) _____
Relationship: _____ Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

Yes No

Who besides yourself is responsible for your bill? Self-Pay Health Insurance

Medicare Medicaid Worker's Comp

Auto Insurance Other (Be Specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Group #: _____

Auto or Workers' Comp Insurance Carrier & Claim #: _____

Please provide a copy of your insurance card & drivers license to staff

PRIMARY COMPLAINT:

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At it's worst ____ At the present time ____ At least severe ____

Does the pain travel? Yes No If yes, from where to where? _____

Is condition getting worse? Yes No

List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped _____

SECOND COMPLAINT:

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At it's worst _____ At the present time _____ At least severe _____

Does the pain travel? Yes No If yes, from where to where? _____

Is condition getting worse? Yes No

List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped _____

THIRD COMPLAINT:

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At it's worst _____ At the present time _____ At least severe _____

Does the pain travel? Yes No If yes, from where to where? _____

Is condition getting worse? Yes No

List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped _____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

Primary Care or Treating Facility name address phone
Number _____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to _____ for services rendered to me.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

PATIENT PRINTED NAME

PATIENT SIGNATURE

DATE

REVIEW OF SYSTEMS

Patient Name: _____ Patient File #: _____ Today's Date: ____ / ____ / ____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:

- None
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:

- None
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (*around the eyes*)
- Photophobia
- Tearing
- Wears Glasses or Contacts

Ears, Nose and Throat:

- None
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection(s)
- Ear Pain
- Fainting
- Headaches
- Head Injury (*history of*)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea (*runny nose*)
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus (*ringing in the ears*)
- TMJ Disorder

Cardiovascular:

- None
- Angina (*chest pain or discomfort*)
- Chest Pain
- Claudication (*leg pain or achiness*)
- Heart Murmur
- Heart Problems
- Orthopnea (*difficulty breathing while lying*)
- Palpitations (*irregular or forceful heart beat*)
- Paroxysmal Nocturnal Dyspnea (*shortness of breath at night*)
- Shortness of Breath
- Swelling of Leg(s)
- Ulcers
- Varicose Veins

Gastrointestinal:

- None
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice (*yellowing of the skin*)
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber (*quality*)
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

Respiration:

- None
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

Endocrine:

- None
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:

- None
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (*numbness, prickling, or tingling*)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

Nervous System:

- None
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:

- None
- Anaphylaxis (*history of*)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology:

- None
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion(s)
- Bruises easily
- Fatigue
- Lymph Node Swelling

Psychological:

- None
- Anhedonia (*inability to experience joy or enjoy life*)
- Anxiety
- Appetite Changes
- Behavioral Change(s)
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change(s)

Female:

- None
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

Male:

- None
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient:

_____ Doctor Signature

_____ Date

Back Index

Form B1100

rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score

Neck Disability Index

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR **NECK PAIN** AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU.

ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- I have no neck pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- I can look after myself normally without causing extra neck pain.
- I can look after myself normally, but it causes extra neck pain.
- It is painful to look after myself, and I am slow and careful
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self -care.
- I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- I can lift heavy weights without causing extra neck pain.
- I can lift heavy weights, but it gives me extra neck pain.
- Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned
- I can lift only very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – READING

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

SECTION 5 – HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

SECTION 7 – WORK

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

SECTION 8 – DRIVING

- I can drive my car without neck pain.
- I can drive my car with only slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.

SECTION 9 – SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

SECTION 10 – RECREATION

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- I am able to engage in a few of my recreational activities because of neck pain.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

PATIENT NAME _____

DATE _____

SCORE _____ [50]

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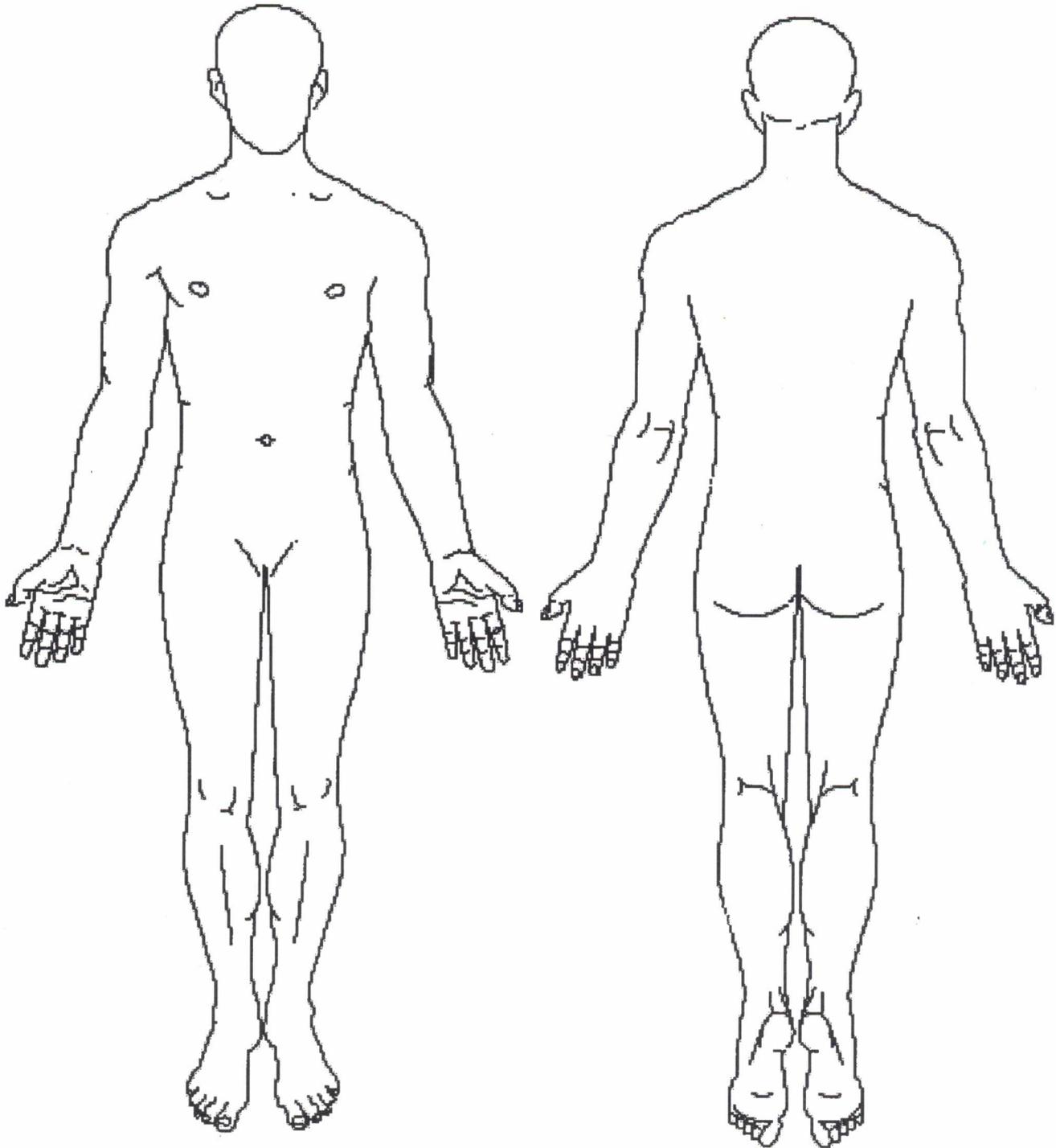
PAIN DRAWING

Patient Name: _____
Attending Dr: _____

Date: _____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face.

A = Ache B = Burning N = Numbness P = Pins and Needles S = Stabbing



Patient Signature: _____
Date: _____