

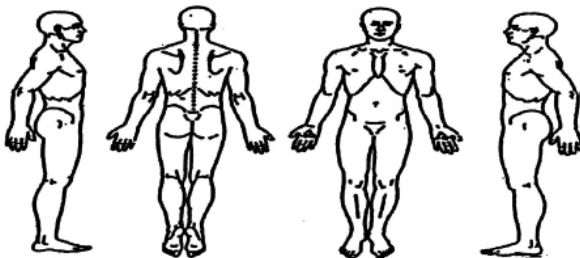
Patient Name: _____

Date: _____

1. Is today's problem caused by:

- Auto Accident
- Workman's Compensation
- Other _____

2. Indicate(circle or X) on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Occasionally (26-50% of the time)
- Frequently (51-75% of the time)
- Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb Dull Tingly
- Diffuse Sharp with motion Achy
- Shooting with motion Burning
- Stabbing with motion Shooting
- Electric like with motion Stiff
- Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same
- Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately
- Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately
- Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist
- Primary Care Physician ER physician
- Orthopedist Massage Therapist
- Physical Therapist No one

Other: _____

10. How long have you had this problem?

OUR OFFICE LOCATIONS

7th Ave Physical Medicine
 & Rehabilitation
 512 7th Avenue, 14th Floor
 New York, NY 10018
 212.768.7979

Downtown Physical Medicine
 & Rehabilitation
 30 Broad Street, 20th Floor
 New York, NY 10004
 212.792.9292

Westside Physical Medicine
 & Rehabilitation
 244 West 54th Street, 3rd Floor
 New York, NY 10019
 212.262.7246

11. How do you think your problem began?

12. What aggravates your problem?

13. What alleviates your problem?
(makes it feel better)

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your:

Height _____ Weight _____
Date of Birth ____/____/____
Occupation _____

16. How would you rate your overall Health?

Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. List all prescription medications you are currently taking: _____

20. List all of the over-the-counter medications you are currently taking:

21. List all surgical procedures you have had:

21. What activities do you do at work?

Sit: Most of the day Half the day
 A little of the day

Stand: Most of the day Half the day
 A little of the day

Computer work: Most of the day

Half the day A little of the day

On the phone: Most of the day

Half the day A little of the day

23. What activities do you do outside of work?

24. Have you ever been hospitalized?

No Yes

If yes, why _____

25. Have you had significant past trauma?

No Yes

26. For each of the conditions listed below, place a check in the “past” column if you have had the condition in the past. If you presently have a condition listed below, place a check in the “present” column.

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/ Stiffnes
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain\	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/ Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Muscular In-coordination
<input type="checkbox"/>	<input type="checkbox"/>	Smoking Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal			
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/ Loss			
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
<input type="checkbox"/>	<input type="checkbox"/>	Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain			
						For Females Only		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy

Other _____

27. Anything else pertinent to your visit today?

Patient Signature _____ Date: _____