Follow-up PM&R Medical History Intake Form

Name_____ Age ____ Date___/___/____

Referred By:_____

Handedness: Right / Left

What problem brings you here today? _____

Is it better or worse than last time (and how much) ? _____

What makes it *worse*? _____

What makes it *better*? _____

What do you want to accomplish from today's visit?

What treatments have you had? (Physical Therapy, Chiropractic, Massage, Injections)	What diagnostic tests have you had for this problem? (X-ray, EMG, MRI, Bone scan, etc)

Please make a *mark on the line* below to indicate the level of discomfort you have today. Example: ——/—— 4 5

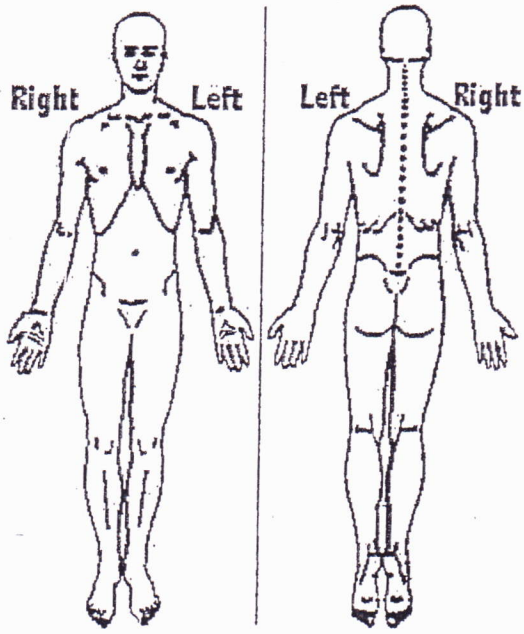
No Pain ——————————————— Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like: (Dull, Achy, Burning, Stabbing, Numbness, Tingling, Pulling, Cramping, Tightness)

Medications:
Please list *ALL* medications including Prescription, Over-the-Counter

Please draw the location of your discomfort



Medical/Surgical History (any changes):

Allergies to Medicines:

Family History (any changes):

What is your Occupation?

Employment status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent	Not working	Retired

Physical requirements of your occupation: (prolonged sitting, prolonged standing, phone, computer, lifting, travel, driving, childcare)

Tobacco use:	Current	Quit	Never

Number of alcoholic beverages per week?

Number of caffeinated beverages per day?

What activities do you need help with at home?

Review of systems: (Please circle each symptom below if Yes)

• Weight change, night pain, fevers?	Yes	No
• Vision change, double vision?	Yes	No
• Difficulty swallowing, headaches?	Yes	No
• Chest pain, palpitations?	Yes	No
• Shortness of breath, asthma?	Yes	No
• Nausea, vomiting, black stools, stool incontinence?	Yes	No
• Urinary or prostate/gynecologic problems?	Yes	No
• Rashes?	Yes	No
• Dizziness, weakness, numbness, tingling?	Yes	No
• Depression, sleep problems?	Yes	No

• What do you do for exercise?

Health Care Provider Initials_____