Midwest Rehabilitation, P.A.

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PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: M F HAND DOMINANCE: R or L

Please describe your main complaint: _____

_____

_____

Date of injury/accident: _____ Work Related: Yes or No Auto Accident: Yes or No

Rate your pain today using the following scale: worst _____ best _____

0	1	2	3	4	5	6	7	8	9	10
No Pain		Weak		Moderate		Strong		Very Strong		Extreme

Indicate how this pain/condition has affected your daily activities:			**Previous Treatment:**
ACTIVITY:	Having Difficulty:	Makes the pain:	(Check all that apply)
Bathing/Hygiene	YES or NO	Better or Worse	☐ Aquatic Therapy
Driving	YES or NO	Better or Worse	☐ Acupuncture
Getting dressed	YES or NO	Better or Worse	☐ Anti-Inflammatory Meds
Going up/down stairs	YES or NO	Better or Worse	☐ Biofeedback
Gripping objects	YES or NO	Better or Worse	☐ Braces
Housework/Yardwork	YES or NO	Better or Worse	☐ Epidural Injections
Lifting/Carrying Objects	YES or NO	Better or Worse	☐ Injections
Reaching Overhead	YES or NO	Better or Worse	☐ Massage
Sitting	YES or NO	Better or Worse	☐ Narcotic Meds
Sleeping	YES or NO	Better or Worse	☐ Physical Therapy
Squatting/Kneeling	YES or NO	Better or Worse	☐ TENS Unit
Standing	YES or NO	Better or Worse	☐ Trigger Point Injections
Walking	YES or NO	Better or Worse	☐ Ultrasound

List all of your current medications and their dosages: (if you need more room, ask for additional paper)	
MEDICATION	DOSAGE

DRUG ALLERGIES	
Please list any known drug allergies.	
DRUG	REACTION

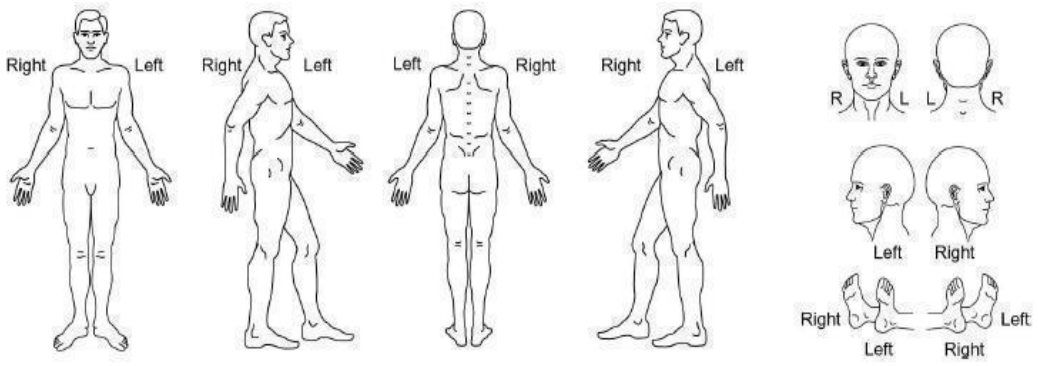
PREVIOUS TESTING:	**DATE:**	**LOCATION:**
☐ CT Scan		
☐ EMG		
☐ MRI		
☐ X-ray		
☐ Other		

CHRONIC HEALTH PROBLEMS (Check all that apply.)	REVIEW OF SYSTEMS (Check all that apply.)		FAMILY HEALTH HISTORY (Check all that apply.)
☐ Addiction: ☐ Alcohol ☐ Rx Drugs ☐ Illegal Drugs ☐ Other	(Check all that are CURRENT or RECENT issues)		☐ Addiction: ☐ Alcohol ☐ Rx Drugs ☐ Illegal Drugs ☐ Other
☐ Anemia	☐ Reading glasses	☐ Issues with urination	☐ Arthritis
☐ Arthritis	☐ Loss of hearing	☐ Shortness of breath	☐ Back Problems
☐ Asthma	☐ Ear pain	☐ Morning cough	☐ Bleeding Disorders
☐ Cancer	☐ Fever or chills	☐ Frequent headaches	☐ Cancer
☐ Diabetes	☐ Heart or chest pain	☐ Blackouts	☐ Diabetes
☐ Gout	☐ Calf cramps w/ walking	☐ Frequent Rash	☐ Gout
☐ Heart Attack / Failure	☐ Poor appetite	☐ Hot or cold spells	☐ Heart Attack / Failure
☐ Hepatitis	☐ Toothache	☐ Recent weight change	☐ High Blood Pressure
☐ High Blood Pressure	☐ Gum trouble	☐ Nervous exhaustion	☐ HIV / AIDS
☐ History of Abuse	☐ Nausea or vomiting		☐ Lung Disease
☐ HIV / AIDS	☐ Stomach pain	**FOR WOMEN ONLY:**	☐ Mental Illness
☐ Lung Disease	☐ Ulcers	☐ Irregular periods	☐ Osteoporosis
☐ Mental Illness: ☐ ADD ☐ OCD ☐ Bipolar ☐ Schizophrenia ☐ Depression ☐ Other	☐ Frequent belching	☐ Vaginal discharge	☐ Seizures
	☐ Frequent diarrhea	☐ Frequent spotting	☐ Stroke
	☐ Change in vision	☐ Other:	☐ Thyroid Issues
	☐ Hoarseness		
	☐ Nosebleeds		
	☐ Difficulty swallowing	☐ NONE OF THE ABOVE	
☐ Osteoporosis	☐ Abnormal heartbeat		
☐ Seizures	☐ Swollen ankles	☐ OTHER: please list	
☐ Stroke	☐ Frequent constipation		☐ OTHER: please list
☐ Thyroid Issues	☐ Hemorrhoids		
☐ Tuberculosis			

SURGICAL HISTORY: ☐ None		
TYPE OF SURGERY:	SURGEON:	DATE:

SOCIAL HISTORY	
Children? Yes or No # and ages of children:	Circle one: Married Divorced Cohabitating Single Widowed
Do you smoke? Yes or No How many per day? If no, did you smoke in the past? Yes or No When did you quit?	Do you drink alcohol? Yes or No Type and amount per week: If no, did you drink in the past? Yes or No
Do you take recreational drugs? Yes or No In the past? Yes or No	Highest level of education? Occupation?

Please mark your areas of pain on the diagram, using an X.



Patient Signature: _____ Date: _____