

**EVALUATION FORM**

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Patient Name: \_\_\_\_\_

**DEMOGRAPHICS**

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: Male/Female Handedness: Right/Left  
 E-mail address: \_\_\_\_\_ Consent Obtained? Yes \_\_\_\_\_ No \_\_\_\_\_

Language Barriers:	Can you understand English? Y____ N____	Can you read English? Y____ N____	1 <sup>st</sup> language preference _____
Primary Care Physician	List other treating physicians:		
Referring Physician:	_____		

**REASON FOR TODAY'S VISIT**

How and when did it start? \_\_\_\_\_  
 What specifically do you want to accomplish with today's visit? \_\_\_\_\_

**ADVANCE DIRECTIVES**

Do you have a living will? (circle one) Y N Need more information  
 Do you have a medical power of attorney? Y N Need more information  
 Do you have an Advanced Directive? Y N Need more information

**PAST MEDICAL HISTORY**

**Major active health condition**  
*(check all that apply)*  
 \_\_\_\_\_ heart disease  
 \_\_\_\_\_ diabetes  
 \_\_\_\_\_ lung disease  
 \_\_\_\_\_ high blood pressure  
 \_\_\_\_\_ kidney problems  
 \_\_\_\_\_ cancer (type) \_\_\_\_\_  
 \_\_\_\_\_ stroke

\_\_\_\_\_ thyroid problems  
 \_\_\_\_\_ seizures  
 \_\_\_\_\_ arthritis  
 \_\_\_\_\_ depression  
 \_\_\_\_\_ asthma  
 \_\_\_\_\_ heartburn  
 \_\_\_\_\_ ulcers  
 \_\_\_\_\_ migraines  
 \_\_\_\_\_ other (please list)

**PAST SURGICAL HISTORY** *(include dates)*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

\_\_\_\_\_

**MEDICATIONS** (Include doses, and all over the counter medications and herbal supplements)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES AND ADVERSE DRUG REACTIONS**

(circle all that apply and list the reaction)  
 \_\_\_\_\_ Penicillin, Sulfa, Contrast Dye, Other \_\_\_\_\_

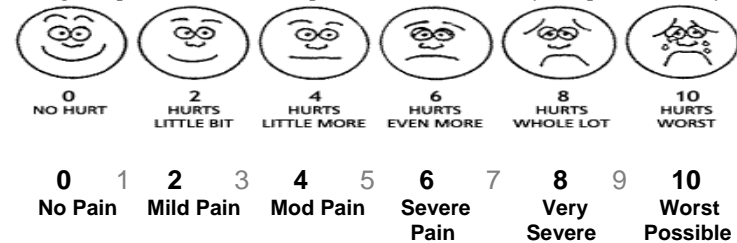
**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ Status: (Circle One) Full-time / Part-time / Restricted-Duty / Off-Duty to Injury / Retired / Not working  
 Last Date of Employment: \_\_\_\_\_  
 Tobacco use: (Circle One) Current / Never / Quit Packs per Day: \_\_\_\_\_ How many years: \_\_\_\_\_  
 Alcohol use: (Circle One) Y N Drinks per week: \_\_\_\_\_

**PAIN**

Do you have pain that you want to discuss with your doctor? Y N  
 Site of Pain: \_\_\_\_\_  
 Quality (circle all that apply): dull /sharp /stabbing /burning /achy /throbbing /shooting/ squeezing/pressure/crampy

Using the pain scale below, please rate how bad your pain is today:



0 NO HURT    2 HURTS LITTLE BIT    4 HURTS LITTLE MORE    6 HURTS EVEN MORE    8 HURTS WHOLE LOT    10 HURTS WORST  
 0 1 2 3 4 5 6 7 8 9 10  
 No Pain Mild Pain Mod Pain Severe Pain Very Severe Worst Possible

When did the pain start? \_\_\_\_\_  
 \_\_\_\_\_  
 What medications have you tried or are currently using to control your pain? \_\_\_\_\_  
 \_\_\_\_\_

# EVALUATION FORM

## PAIN HISTORY:

What makes the pain *worse*? \_\_\_\_\_ Sitting Standing Walking Lying Moving

What makes the pain *better*? \_\_\_\_\_ Sitting Standing Walking Lying Moving

Is this related to a fall or MVA? Y N

Is this a work-related injury? Y N

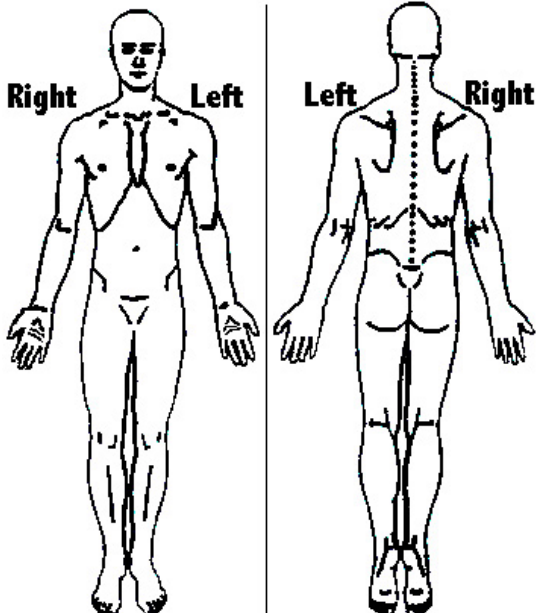
Is there litigation pending? Y N What tests have you had: Xrays EMG MRI CT Scan

Which treatments have you tried for this problem: PT Acupunct. TENS Massage Psych  
(Circle helpful treatments and cross-out unhelpful ones): Chiro Injections Braces Exercise Surgery

Please list specific dates and specifics of treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Please draw the location of your discomfort

	<b>Have you ever had?</b>		Yes	No
	Difficult swallowing, headaches Chest pain, palpitations Shortness of breath, asthma Nausea, vomiting, black stools Loss of bowel or bladder control Urinary or prostate/gynecologic issues Rashes Dizziness, weakness, numbness, tingling Depression, sleep problems Prior musculoskeletal problems Easy bleeding, on blood thinners			

## NUTRITION

Have you ever had? (check all that apply)

- \_\_\_ Inability to eat
- \_\_\_ Are you pregnant or lactating?
- \_\_\_ Unintentional weight loss
- \_\_\_ Unintentional weight gain
- \_\_\_ Swallowing difficulties or chewing problems
- \_\_\_ Special diet requirements for your (circle) kidneys/liver/heart/diabetes
- \_\_\_ Would you like to see a nutritionist
- \_\_\_ Questions about how your diet may impact your current health/medical condition

## LEARNING/EDUCATION

Are there any? (check all that apply)

- \_\_\_ Cultural/social/spiritual barriers to learning about your condition
- \_\_\_ Physical barriers to learning about your condition
- \_\_\_ I want to learn more about my medical condition(s)? Y N
- How do you learn best? (circle)  
Verbal Demonstration Written Visual
- Highest grade completed: (circle)  
Grade School High School Postgraduate

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Initials of Reviewing Physician: \_\_\_\_\_