RehabOne
RehabOne Programs | MEDICAL GROUP, INC

New Patient Questionnaire

Patient name: _____ **Date completed:** _____

Date of Birth: _____ **Age:** _____ **Date of Injury:** _____

Do you have any allergies or medication reactions? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

What are you being seen for today?

_____

_____

_____

Describe how your injury/problems happened:

_____

_____

_____

_____

_____

_____

Describe any other serious injuries/problems:

_____

_____

_____

_____

_____

Have you had any of the following studies done related to your injury? (check all that apply):

☐ X-Ray ☐ MRI ☐ Nerve studies ☐ CT Scan ☐ Ultrasound ☐ Recent bloodwork

Have you had any of the following treatments related to your injury? (check all that apply):

☐ Surgery ☐ Physical Therapy ☐ Pain counseling ☐ Injections ☐ Acupuncture ☐ Yoga

☐ Chiropractic ☐ Medications

Activities of Daily Living: Put an X in the appropriate boxes

Activities	Able to do without pain	Able to do with pain	Unable to do
Self-Care			
Dressing			
Combing hair			
Bathing/Showering			
Getting on and off the toilet			
Brushing teeth			
Eating			
Cooking			
Communication			
Seeing			
Hearing			
Speaking			
Physical Activity			
Sitting			
Standing			
Walking on uneven ground			
Climbing stairs			
Light housework			
Heavy housework			
Sensory			
Feeling			
Smelling			
Tasting			
Hand Activities			
Writing			
Typing			
Opening doors			
Opening jars			
Turning faucets on and off			
Folding laundry			
Travel			
Getting in and out of a car			
Driving			
Flying			

How long are you able to walk at a time? ☐30 mins ☐1 hour ☐2 hours ☐3 hours ☐4+ hours ☐other: ____

How long are you able to sit at a time? ☐30 mins ☐1 hour ☐2 hours ☐3 hours ☐4+ hours ☐other: ____

How long are you able to stand at a time? ☐30 mins ☐1 hour ☐2 hours ☐3 hours ☐4+ hours ☐other: ____

How many pounds are you able to carry? ☐Up to 10lb ☐Up to 20lb ☐Up to 30lb ☐Up to 40lb ☐50lb+ ☐other::__

How many pounds are you able to lift? ☐Up to 10lb ☐Up to 20lb ☐Up to 30lb ☐Up to 40lb ☐50lb+ ☐ other:__

Describe your symptoms: (please circle for each body part)

Body Part: ______________________________

Frequency	**Quality**	**Additional Comments**
All of the time	Aching	________________________________
Most of the time	Burning	________________________________
Comes and goes	Stabbing	________________________________
Not often	Pins and Needles	________________________________

Body Part: ______________________________

Frequency	**Quality**	
All of the time	Aching	________________________________
Most of the time	Burning	________________________________
Comes and goes	Stabbing	________________________________
Not often	Pins and Needles	________________________________

Body Part: ______________________________

Frequency	**Quality**	
All of the time	Aching	________________________________
Most of the time	Burning	________________________________
Comes and goes	Stabbing	________________________________
Not often	Pins and Needles	________________________________

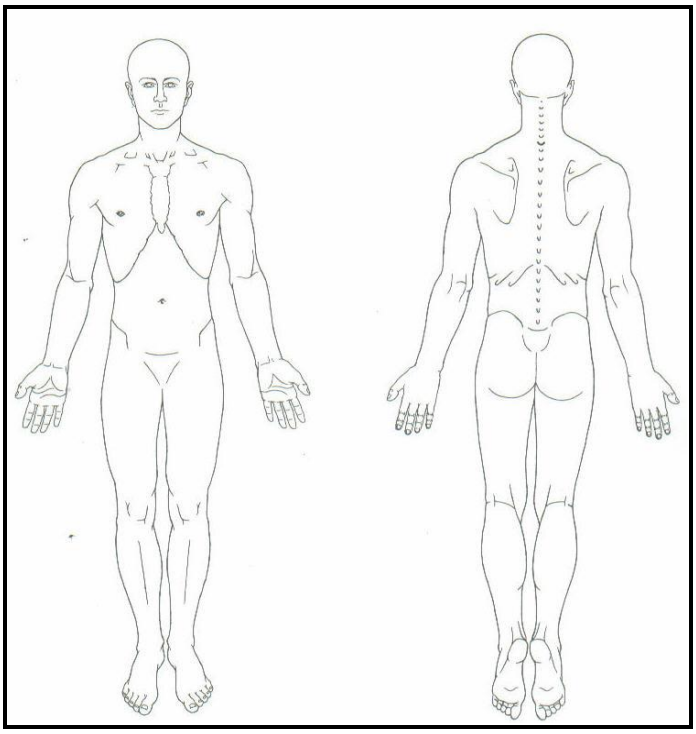
Body Part: ______________________________

Frequency	**Quality**	
All of the time	Aching	________________________________
Most of the time	Burning	________________________________
Comes and goes	Stabbing	________________________________
Not often	Pins and Needles	________________________________

Body Part: ______________________________

Frequency	**Quality**	
All of the time	Aching	________________________________
Most of the time	Burning	________________________________
Comes and goes	Stabbing	________________________________
Not often	Pins and Needles	________________________________

Mark an X on the spots that you have pain:



Please circle a number from the scales below:

At its <u>best</u>, how would you rate your overall pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

At its <u>worst</u>, how would you rate your overall pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

<u>Today</u>, how would you rate your overall pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Surgeries (Check all that apply):

☐ Neck ☐ Spine ☐ Leg ☐ Foot

☐ Knee ☐ Arm ☐ Hand

☐ Other:_____

Personal and Family Medical Conditions:

	<u>You</u>	<u>Family</u>
Alcohol abuse	☐	☐
Anemia	☐	☐
Angina (chest pain)	☐	☐
Anxiety	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bipolar disorder	☐	☐
Bleeding disorder	☐	☐
Cancer	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Gallbladder	☐	☐
Glaucoma	☐	☐
Gout	☐	☐
Headaches	☐	☐
Head injury	☐	☐
Heart Attack	☐	☐
Heart murmur	☐	☐
Hepatitis/liver disease	☐	☐
High blood pressure	☐	☐
High Cholesterol	☐	☐
Insomnia	☐	☐
Kidney disease	☐	☐
Lung disease	☐	☐
Recurrent fevers	☐	☐
Seizures	☐	☐
Shortness of breath	☐	☐
Sleep Apnea	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Ulcer	☐	☐

Other _____

For women:

Are you currently pregnant? ☐ Yes ☐ No

Personal History

Which hand do you write with? ☐ Right ☐ Left

Social History:

Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Do you have children? ☐ Yes ☐ No If Yes, please list ages: _____

Who do you live with? (Check all that apply)

☐ Alone ☐ Spouse ☐ Children ☐ Parents ☐ Roommates ☐ Other: _____

Circle the highest level of school completed: 1 2 3 4 5 6 7 8 9 10 11 12 ☐ G.E.D

☐ College (☐ Some ☐ Associates Degree ☐ Bachelor's Degree) ☐ Graduate School ☐ Trade School

How often do you exercise? ☐ never ☐ rarely ☐ occasionally ☐ regularly

Please List any current Hobbies/Sports: _____

_____

_____

_____

Alcohol:	☐ Current	☐ Former	☐ Never	**If current:** ☐ regularly ☐ occasionally ☐ rarely
Cigarettes/Tobacco:	☐ Current	☐ Former	☐ Never	**If current:** ☐ regularly ☐ occasionally ☐ rarely
Medicinal Marijuana:	☐ Current	☐ Former	☐ Never	**If current:** ☐ regularly ☐ occasionally ☐ rarely
Recreational drugs:	☐ Current	☐ Former	☐ Never	**If current:** ☐ regularly ☐ occasionally ☐ rarely

Vocational Status:

Company and Job title at time of the Injury: _____

Are you currently employed? ☐ Yes ☐ No If no: ☐ Laid-off ☐ Quit ☐ Retired ☐ Terminated

If yes, what is the name of the current company and job title? _____

☐ Full Time ☐ Part Time

Disability Status:

Are you currently receiving workers' compensation disability benefits? ☐ Yes ☐ No
If yes, check the appropriate box: ☐ Temporary disability benefits ☐ Permanent disability benefits

Have you been determined to be permanent and stationary? ☐ Yes ☐ No ☐ Don't know
If yes, what is the date and the physician's name who declared you permanent and stationary?

_____/____/____ (date) _____ (physician's name)

Are you currently receiving Social Security benefits?	☐ Yes	☐ No
Are you currently receiving long term disability benefits?	☐ Yes	☐ No
Are you currently receiving State Disability benefits?	☐ Yes	☐ No
Are you currently receiving unemployment benefits?	☐ Yes	☐ No

Current Medications (include all prescribed and over the counter, including supplements):

Name	Strength	Dosage (example 2x day)	Average number taken weekly

Review of Systems: (check all that apply)

General
☐ Change in appetite
☐ Fever
☐ Extreme daytime sleepiness
☐ Poor sleep
☐ Weight changes
☐ Irritability
☐ Sexual problems
☐ Fatigue (feeling tired)
☐ Night sweats
☐ Physical/Emotional abuse

Cardiovascular
☐ Chest pain
☐ Irregular heartbeat
☐ Edema (leg swelling)
☐ High Blood Pressure
☐ Murmur

Endocrine
☐ Extreme hunger
☐ Extreme sweating
☐ Extreme thirst
☐ Unusual hair loss
☐ Cold intolerance
☐ Heat intolerance
☐ Thyroid Problems

Gastrointestinal
☐ Abdominal pain
☐ Bloating
☐ Blood in stool
☐ Change in bowel habits
☐ Constipation
☐ Diarrhea
☐ Fecal incontinence
☐ Food intolerance
☐ Gallstones
☐ Heartburn
☐ Hemorrhoids
☐ Liver problems
☐ Indigestion
☐ Jaundice
☐ Laxative use
☐ Nausea
☐ Vomiting
☐ Vomiting blood

Head
☐ Deformity
☐ Dental Problems
☐ Head injury
☐ Headache
☐ Nosebleeds
☐ Sinus problems
☐ Trouble swallowing
☐ Visual changes

Musculoskeletal
☐ Arthritis
☐ Muscle wasting
☐ Crepitation
☐ Bone deformity
☐ Gout
☐ Limitation of motion
☐ Muscle cramp
☐ Back pain
☐ Bone pain
☐ Joint pain
☐ Muscle pain
☐ Stiffness

Neck
☐ Enlarged Thyroid
☐ Neck mass
☐ Neck pain
☐ Stiffness
☐ Swollen glands

Neurological
☐ Abnormal Gait
☐ Blackouts
☐ Clumsiness
☐ Concentration problems
☐ Confusion
☐ Dizziness
☐ Fainting
☐ Focal weakness
☐ Increased sensation
☐ Decreased sensation
☐ Incoordination
☐ Involuntary movement
☐ Numbness
☐ Paralysis
☐ Seizures
☐ Tingling
☐ Tremors
☐ Weakness

Peripheral Vascular
☐ Blood clots
☐ Cold feet
☐ Cold hands
☐ Cramps
☐ Varicose veins

Psychiatric
☐ Anxiety
☐ Depression
☐ Hallucinations
☐ Insomnia
☐ Irritability
☐ Mood swings
☐ Panic episodes

☐ Paranoia
☐ Suicidal thoughts
☐ Memory problems

Respiratory

☐ Chest wall pain
☐ Coughing
☐ Coughing up blood
☐ Shortness of breath
☐ Snoring
☐ Tuberculosis
☐ Wheezing

Skin

☐ Acne
☐ Changes in hair
☐ Changes in skin pigment
☐ Dry skin
☐ Hives
☐ Itching
☐ Sores
☐ Lumps
☐ Rash

Urinary

☐ Blood in urine
☐ Burning with urination
☐ Decrease urine stream
☐ Delayed urination
☐ Dribbling
☐ Flank pain
☐ Incontinence
☐ Infection
☐ Kidney stones
☐ Night time urination
☐ Painful Urination
☐ Urine retention

If there is something else that you would like the doctor to know, please use additional sheets.

Did anyone help you to complete this questionnaire? ☐ Yes ☐ No

Name: _____ **Relationship:** _____

Thank you for taking the time to complete this questionnaire!

Patient signature: _____ **Date:** _____