Rehab Medicine OF THE CAROLINAS

NEW PATIENT QUESTIONNAIRE

Name: ______________________________________ SS #: ____

Today's Date: ________________________________ Primary Care Doctor:___________________________

DOB: ______________________________________ Referring Doctor:_______________________________

What would you like addressed at today's visit? ____

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1. **Symptom Assessment**

Below is a list of symptoms. If you have had the symptom **DURING THE PAST WEEK,** place an "X" in the "Yes" box. If you had the symptom, place an "X" in the box that tells how much the symptom distressed or bothered you.

DURING THE PAST WEEK **Did you have any of the following symptoms**	**YES [x]**	**If YES, How much did it DISTRESS or BOTHER you?**				
		Not at all	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
Pain						
Fatigue/lack of energy						
Constipation						
Numbness/tingling						
Difficulty sleeping						
Urinary accidents						
Bowel accidents						
Lack of appetite						
Taste disturbance						
Dizziness						
Balance problems						
Difficulty with memory or concentration						
Feeling sad/depressed						
Feeling nervous/anxious						
Weakness						
Difficulty speaking (articulation)						
Choking or coughing after eating/drinking						

2**. If you have pain, Please complete the following**:

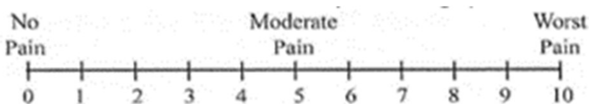
When did your pain begin?_________________________

Has the pain changed?___________________________

Does anything make it better? ____________________

Or worse? ______________________________________

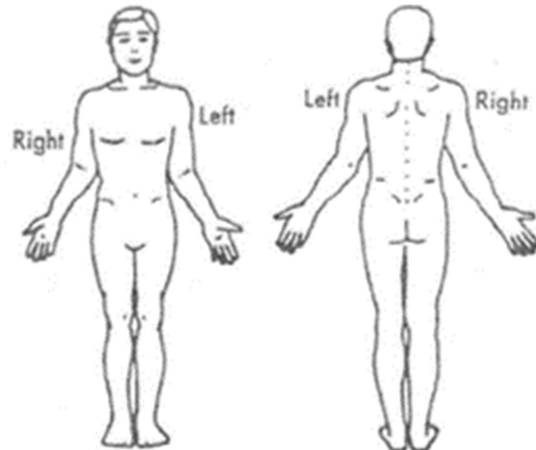
Circle the number that describes your average pain:



Circle previous treatments you have had for pain:

Acupuncture	Biofeedback	Brace
Chiropractor	Epidural	Exercise
Physical therapy	Facet block	Hypnosis
Massage	Nerve block	Psychotherapy
Surgery	TENS	Trigger Points

Shade the location(s) you have pain:



Describe the quality of the pain ___________________

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3. **Functional Status Questions**

How much help do you need with these activities? Place an "X" in the appropriate box

	None	A Little	Moderate Amount	A lot
Eating				
Bathing				
Dressing				
Toileting				
Walking				
Transfers (ie.standing from seated position, turning in bed, getting to the bathroom, moving from bed to chair)				

Please select the category that you feel best reflets your current function

- O Fully active, able to do activities without restriction
- O Able to walk but unable to do physically strenuous activity; able to do light work
- O Able to walk and perform self-care but unable to do any work activities; spend less than 50% of your day out of bed
- O Spend more than 50% of your day in bed; difficulty providing self care
- O Bedbound or totally chair confined; unable to provide any self-care.

Wben is the last time you exercised regularly?

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What is your home exercise program?

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4. **Social History**

Do you use tobacco products? ________________________

If yes, what type & how often? ________________________

If former smoker, quit date? __________________________

Do you use alcohol? _________ How often? _____________

Do you use illegal drugs? ____________________________

Who lives at home with you? _________________________

What is your marital status? _________________________

What is your occupation? ____________________________

Highest grade level completed? _______________________

5. **Family History**

Please circle any of the following that runs in your family:

Lupus	Arthritis	Cancer
Heart Disease	Depression	Stroke
Substance Abuse	Diabetes	Bleeding Disorder
Other		

6. **Past Medical History**. List all medical conditions

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7. **Past surgical history**. List all previous surgeries

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8. **Current medications with dose and frequency**

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9. **What pharmacy would you like any prescriptions sent?**

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10. **Allergies**

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