

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

MR#: \_\_\_\_\_

Age: \_\_\_\_

Follow Up Medical History Intake Form

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred By: \_\_\_\_\_

CC: What problem/issue brings you here today?

HPI: Since your last physician visit, are your symptoms ...	Better	Worse	Same
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If better, by how much on a scale of 0-100%? (if 0 was the way you were and 100% was completely normal) %

What makes it worse?	walking	sitting	standing	lying down	nothing	exercise	Other:
What do you want to accomplish from today's visit?	Diagnosis	Treatment Options	X-ray Rx	MRI Rx	Med Rx	Review Test	Injection Rx
Are you currently in physical therapy?		No	Yes				
If you had an injection since last visit, was it helpful?	N/A	No	Yes	Yes, but only for ____ days / weeks / months			

Please make a mark on the line below to indicate the level of discomfort you have today.

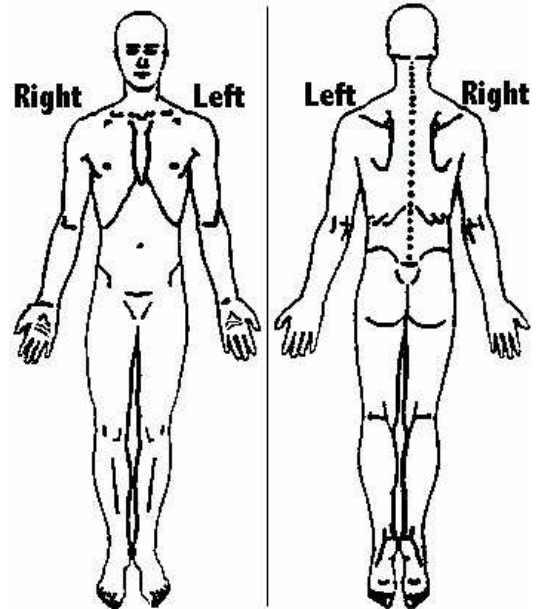
No Pain \_\_\_\_\_ Worst Pain Ever  
0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like: Dull, Achy, Burning, Stabbing, Numbness, Tingling, Pulling, Cramping, Tight, Stiff

Please describe the time course of your pain: Constant, Comes and goes, Getting worse, Getting better, Staying about the same

Social History: What do you do for exercise?				
Employment status:	Full-time	Part-time	Light Duty	Off Duty due to injury
		Full-time Parent	Not working	Retired

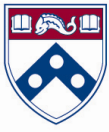
Please draw where you have Pain



ROS	Fevers?	Yes	No
	Headaches?	Yes	No
	Loss of control of stools?	Yes	No
	Loss of control of urine?	Yes	No
	New weakness, numbness, tingling?	Yes	No
♀	Are you pregnant, trying to get pregnant or breastfeeding?	Yes	No

Patient's Signature: \_\_\_\_\_

Physician Initials/Date/Time: \_\_\_\_/\_\_\_\_/\_\_\_\_



## Pain Disability Index

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

Date: \_\_\_/\_\_\_/\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. Please select the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK.

A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply.

**FAMILY/HOME RESPONSIBILITIES:** This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g., yard work, house cleaning) and errands or favors for other family members (e.g., driving the children to school).

0	1	2	3	4	5	6	7	8	9	10
No Disability			Mild		Moderate			Severe		Total Disability

**RECREATION:** This category includes hobbies, sports, and other similar leisure time activities.

0	1	2	3	4	5	6	7	8	9	10
No Disability			Mild		Moderate			Severe		Total Disability

**SOCIAL ACTIVITY:** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0	1	2	3	4	5	6	7	8	9	10
No Disability			Mild		Moderate			Severe		Total Disability

**OCCUPATION:** This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as housewife or volunteer worker.

0	1	2	3	4	5	6	7	8	9	10
No Disability			Mild		Moderate			Severe		Total Disability

**SEXUAL BEHAVIOR:** This category refers to the frequency and quality of one's sex life.

0	1	2	3	4	5	6	7	8	9	10
No Disability			Mild		Moderate			Severe		Total Disability

**SELF-CARE:** This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed).

0	1	2	3	4	5	6	7	8	9	10
No Disability			Mild		Moderate			Severe		Total Disability

**LIFE-SUPPORT ACTIVITY:** This category refers to basic life-supporting behaviors such as eating and sleeping.

0	1	2	3	4	5	6	7	8	9	10
No Disability			Mild		Moderate			Severe		Total Disability

Office Use Scoring: Sum Total: \_\_\_/70