Rehabilitation Physicians, PC

Relieving Pain and Restoring Lives

PATIENT INFORMATION FORM FOR NEW AND RE-ESTABLISHED PATIENTS (Consults, New Patients, Limited Consults)

(Please complete the following)

DATE ______________ NAME ______________________________ DOB ____________ AGE ______

R/L HANDED _______ MARITAL STATUS ______ # OF CHILDREN _______ AGES ______________ HEIGHT ______________ WEIGHT __________

CURRENT PROBLEM(S) ______________________________

____

____

WHEN DID IT START? ______________________________

REASON PROBLEM STARTED ______________________________

WHAT TESTS (and results) HAVE YOU HAD FOR THIS PROBLEM?

____

WHAT TREATMENT (heat, ice, rest, medications [by name], therapy)

HAVE YOU HAD FOR THIS PROBLEM? BE SPECIFIC:

____

____

HOSPITALIZATIONS FOR THIS PROBLEM ______________________________

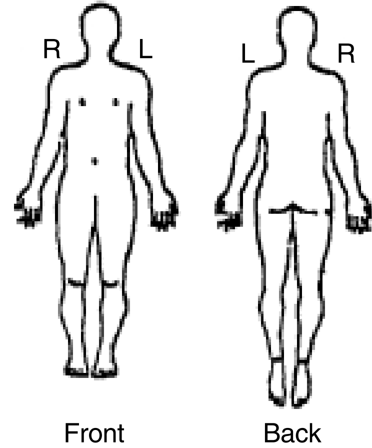
WHO REFERRED YOU? ______________________________

PHYSICIANS' NAMES: Primary Care: ______________________________

PHYSICIANS YOU HAVE SEEN FOR THIS PROBLEM ______________________________

____

WHERE IS YOUR PAIN?



Aching = ^ ^ ^ ^ ^   Burning = -------

Stabbing = ///////   Numbness/Tingling = oooooo

DOES PAIN AWAKEN YOU FROM A SOUND SLEEP? Yes ❑ No ❑ SEVERITY (Normal = 0 - - - - > Excessive = 10) ______________

WHAT MAKES THE SYMPTOMS BETTER ? ______________________________

WHAT MAKES THE SYMPTOMS WORSE? ______________________________

OTHER ASSOCIATED SYMPTOMS (numbness, pain elsewhere) ______________________________

PAST HISTORY

OTHER MEDICAL PROBLEMS ______________________________

SURGERIES AND DATES ______________________________

PREVIOUS ACCIDENTS ______________________________

CURRENT MEDICATIONS ______________________________

ALLERGIES TO MEDICATIONS ______________________________

OTHER PROBLEMS: Review of Systems

	Yes	No		Yes	No		Yes	No
			Bladder	❑	❑	Psychiatric	❑	❑
Head	❑	❑	Bowel	❑	❑	Weight Gain	❑	❑
Throat	❑	❑	Fever/Chills	❑	❑	Weight Loss	❑	❑
Chest	❑	❑	Muscles	❑	❑	Appetite	❑	❑
Heart	❑	❑	Bones	❑	❑	Blood	❑	❑
Abdomen	❑	❑	Skin	❑	❑	Endocrine Glans	❑	❑

DESCRIBE ______________________________

SOCIAL HISTORY:

OCCUPATION (Type and Employer) ______________________________

ARE YOU PARTICIPATING IN SPORTS? ___________ WHAT TYPE? ______________________________

ARE YOU WORKING NOW? Yes ❑ No ❑ LAST DAY WORKED _____________ DO YOU PERFORM HOUSEWORK? Yes ❑ No ❑

SMOKE? Yes ❑ No ❑ HOW MUCH? ______________________ ALCOHOL? Yes ❑ No ❑ STREET DRUGS? Yes ❑ No ❑

FAMILY HISTORY: (Medical problems in close relatives) ______________________________

FOR FEMALES ONLY: COULD YOU BE PREGNANT? Yes ❑ No ❑ ARE YOU BREAST FEEDING? Yes ❑ No ❑

______________________________   ______________________________

PHYSICAL EXAMINATION: ** Can use **N** for Normal

1) NAME ____________________ DATE ____________

RESP ________ HGT ________ WT ________ B/P ________ PULSE ________ TEMP ________

2) APPEARANCE ____________________

GAIT ____________________

Inspection/Palpation Range-of-Motion Stability Strength and Tone

3-6) NECK ____________________

BACK ____________________

RUE ____________________

LUE ____________________

RLE ____________________

LLE ____________________

7) SKIN: NECK ________ BACK ________ RUE ________ LUE ________ RLE ________ LLE ________

8) COORDINATION

9) REFLEXES

10) SENSATION

11) MENTAL STATUS

12) MOOD AFFECT

LANGUAGE

KNOWLEDGE/MEMORY

13) PERIPH. PULSES, VARICOSITIES, EDEMA, ETC.

14) LYMPH NODES, AXILLA, NECK AND/OR GROIN

TEST RESULTS:

OTHER REPORTS:

DIAGNOSES:

PLAN:

RISK OF COMPLICATIONS/SEVERITY:

INSTRUCTION/COUNSELING:

GOALS:

PROGNOSIS:

OTHER/PATIENT QUESTIONS:

3/3 Elements	99202	99203	99204	99205
HPI	1-3 Elements	4 or More Elements	4 or More	4 or More
ROS	N/A	Related to HPI & 2-9 Negs.	Related to HPI & 2-9 Negs.	10
PFSH	N/A	1 item from any 3 areas	1 item from any 3 areas	1 from each of 3 areas
EXAM	Affected body area only	6 Elements	12 Elements	All Elements
DECISION MAKING (See sheets in rooms for more detail)	1 Minor problem	2 or more minor problems	2 or more minor problems	2 or more stable chronic or 1 with exacerbation

RETURN VISIT ____________ PHYSICIAN SIGNATURE ____________________