Rehabilitation Physicians, PC
Relieving Pain and Restoring Lives

PATIENT INFORMATION FORM FOR ESTABLISHED PATIENTS (Rechecks)
(PLEASE COMPLETE EVERYTHING ABOVE THE DOTTED LINE, AND ONLY THOSE AREAS THAT HAVE CHANGED BELOW THE DOTTED LINE)

Date: _____ Name: _____ DOB: _____ Age: _____ Occupation: _____

Current Problem(s): _____

_____

_____

Severity (Normal = 0 - - - - - > Excessive = 10) _____

Are you better? Yes ❑ % Better _____; Same? Yes ❑ ; Worse? Yes ❑ % Worse _____; Is there night pain? Yes ❑ No ❑

What makes the symptoms better? _____

_____

Worse? _____

_____

Other Associated Symptoms? _____

_____

• • • • • • • • • • • • • • • • • • • •

What **NEW TREATMENT** and/or **MEDICATIONS** are you using now? _____

_____

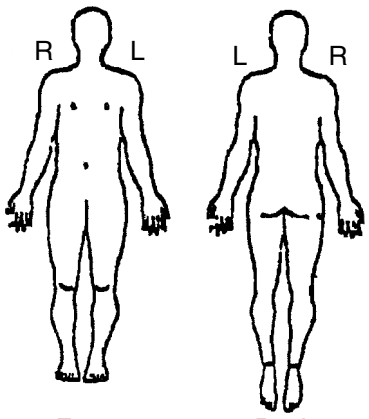
_____

_____

What **OTHER TESTS** have you had? _____

_____

Where is your Pain?



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

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

(CHANGES FROM PREVIOUS VISIT)

PAST HISTORY: (Accidents, Illnesses, Surgeries) _____

_____

Allergies to Medications: _____

OTHER PROBLEMS: Review of Systems

	Yes	No		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 Glands	❑	❑

SOCIAL HISTORY: Are you performing your own housework? YES ❑ NO ❑

Are you working now? YES ❑ NO ❑ If NO, Last Day Worked: _____

Full Duty ❑ Limited Duty ❑ Explain: _____

Are you participating in sports? YES ❑ NO ❑

OTHER: _____

_____

_____ _____

Physician Signature Patient Signature

(Do not write below this line)

Notes:

Height: _____ Weight: _____ Change from last visit: _____ BP: _____ Pulse: _____

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:

2/3 Elements	99212	99213	99214	99215
HPI	1-3 Elements	1-3 Elements	4 or More	4 or More
ROS	N/A	Related to HPI	Related to HPI & 2-9 Negs.	10
PFSH	N/A	N/A	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 stable chronic	2 or more stable chronic or 1 with exacerbation

RETURN VISIT _____ PHYSICIAN SIGNATURE _____