RUSH

Rush Copley Medical Group

Patient Health Questionnaire

IDN13150147

ALL FIELDS MUST BE COMPLETED

NEW PATIENT HISTORY FORM

Date of Visit: _____

Name:	**Date of Birth:**	❑ Male ❑ Female ❑ Right-handed ❑ Left-handed
Primary Care Doctor (Name, Address, Phone #)**:**		
Referring Doctor (Name, Address, Phone #)**:**		
Other Doctors Involved in Your Care (Name and Specialty)**:** **1.**		
2.		

PRESENT PROBLEM

What is your primary complaint?
When did it begin?
What caused it?
What makes it better?
What makes it worse?
Any related symptoms?
What treatments have you tried and for how long? (e.g. PT, injections, chiropractor, etc.)
Is this a work-related problem? Date of accident?
Anything else we should know?

MEDICAL HISTORY

Medical Problems (e.g. diabetes, hypertension)

Surgeries (please include year and hospital)

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Medications and Doses (e.g. Aspirin 81 mg daily)	**Allergies and Reactions** (e.g. Penicillin – rash)
❑ List attached	❑ No known allergies

REVIEW OF SYSTEMS

(Please only check the problems you are **currently** experiencing)

Constitutional: ❑ Fever ❑ Night sweats ❑ Weight gain ❑ Weight loss	**Cardiovascular:** ❑ Chest pain ❑ Palpitations	**Respiratory:** ❑ Shortness of breath ❑ Wheezing ❑ Coughing up blood	**Gastrointestinal** ❑ Blood in stool ❑ Nausea/vomiting ❑ Diarrhea ❑ Constipation
Genitourinary: ❑ Poor control of bladder ❑ Burning with urination ❑ Sexual dysfunction	**Musculoskeletal:** ❑ Neck pain ❑ Back pain ❑ Loss of muscle bulk ❑ Muscle spasms	**Psychosocial:** ❑ Depression ❑ Anxiety ❑ Mood swings ❑ Hallucinations	**Hematologic:** ❑ Easy bruising or bleeding ❑ Frequent nose bleeds ❑ Lymph node swelling
Skin and Breast: ❑ Body rash or hives ❑ Discharge from nipples ❑ Problems with wound healing	**Endocrine:** ❑ Cold intolerance ❑ Heat intolerance ❑ Excessive thirst ❑ Excessive urination	**Neurologic:** ❑ Poor/double vision ❑ Loss of hearing ❑ Headaches ❑ Speech difficulty	**Other:** ❑ ❑ ❑ ❑

FAMILY HISTORY

	Alive?	Age	Significant Health Problems		Age	Significant Health Problems
Mother				**Children**		
Father						
Siblings						

SOCIAL HISTORY

Education (highest level): ❑ Less than high school ❑ Some high school ❑ High school diploma ❑ Some college ❑ College degree ❑ Post-college degree	**Marital Status:** ❑ Single ❑ Married ❑ Widow(er) ❑ Divorced	**Work Status:** ❑ Occupation: _____ ❑ Working full-time ❑ Working part-time ____ hours/week ❑ Retired for ____ years ❑ Disabled for ____ years
Tobacco: ❑ Currently smoke _____ packs/day for _____ years ❑ Quit smoking _____ years ago ❑ Never smoked ❑ Use/used smokeless tobacco (e.g. snuff or chew): _____	**Alcohol:** ❑ Currently drink _____ alcoholic drinks per week ❑ Quit drinking _____ years ago ❑ Never drank alcohol	**Drugs:** ❑ Currently use recreational/street drugs (cocaine, marijuana, LSD, heroin, etc.) ❑ Quit using drugs _____ years ago ❑ Never used drugs

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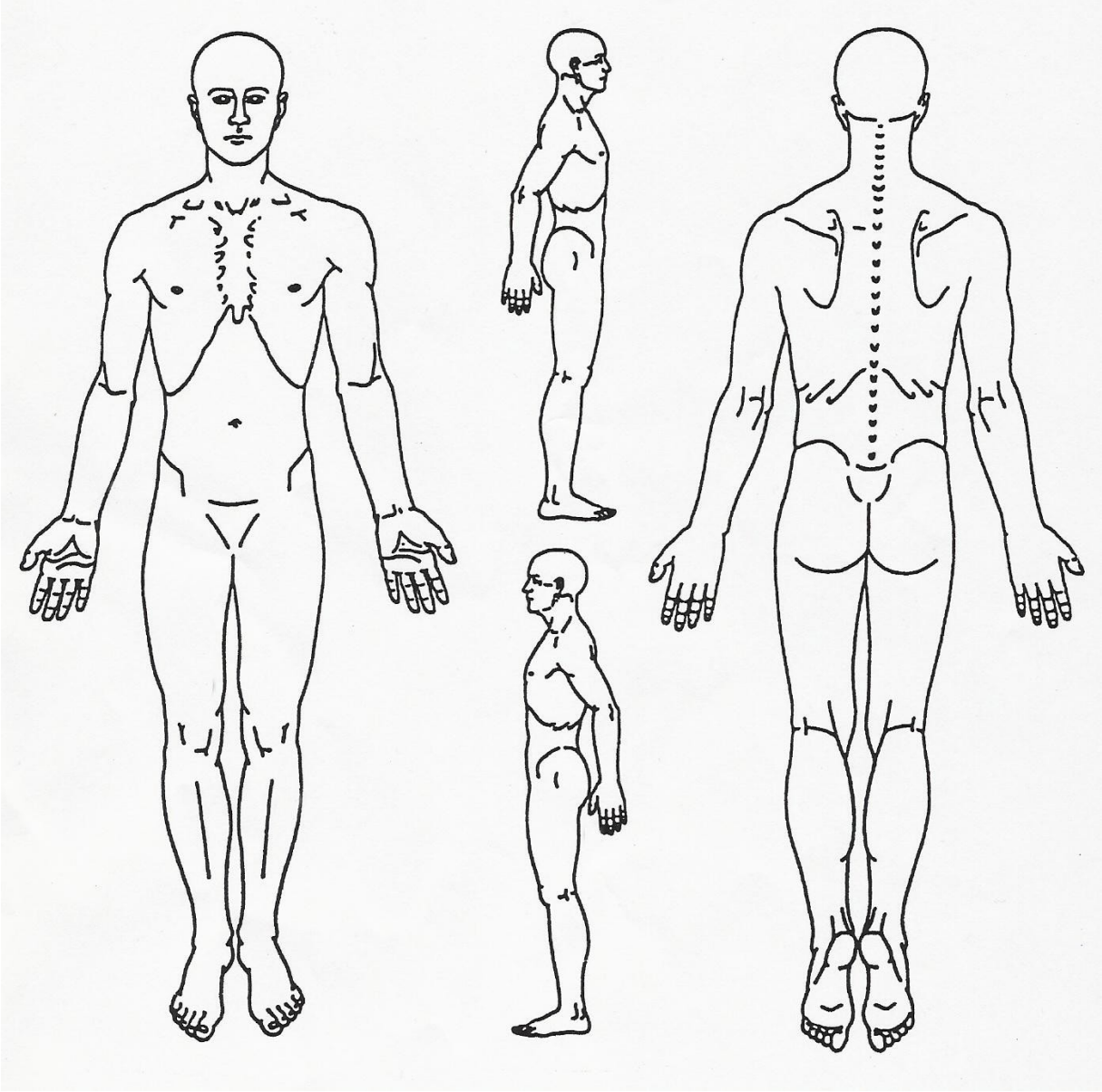
PAIN DIAGRAM

1. On the pictures below, please mark with "x" where you are experiencing pain and with "o" where you are experiencing numbness:

Pain: xxxxxxxxxxxx **Numbness: ooooooooooo**



2. Please circle the number that best corresponds to how much <u>pain</u> you experience in each of these areas <u>on an average day</u> (0 = no pain, 10 = unbearable pain):

Neck:	0	1	2	3	4	5	6	7	8	9	10
Right arm:	0	1	2	3	4	5	6	7	8	9	10
Left arm:	0	1	2	3	4	5	6	7	8	9	10

Back:	0	1	2	3	4	5	6	7	8	9	10
Right leg:	0	1	2	3	4	5	6	7	8	9	10
Left leg:	0	1	2	3	4	5	6	7	8	9	10

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OSWESTRY DISABILITY INDEX

Please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer **every section**. Mark **one box only** in each section that most closely describes you **today**.

1. Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

2. Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

3. Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

4. Walking
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ¼ of a mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

5. Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ an hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

6. Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

7. Sleeping
- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☐ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

8. Sex Life (if applicable)
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

9. Social Life
- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

10. Traveling
- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from travelling except to receive treatment.