



Rush Copley Medical Group

Patient Name: _____

Patient Date of Birth: _____

ALL FIELDS MUST BE COMPLETED

Medications and Doses (e.g. Aspirin 81 mg daily)	Allergies and Reactions (e.g. Penicillin – rash)
<input type="checkbox"/> List attached	<input type="checkbox"/> No known allergies

REVIEW OF SYSTEMS

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

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

FAMILY HISTORY

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

SOCIAL HISTORY

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

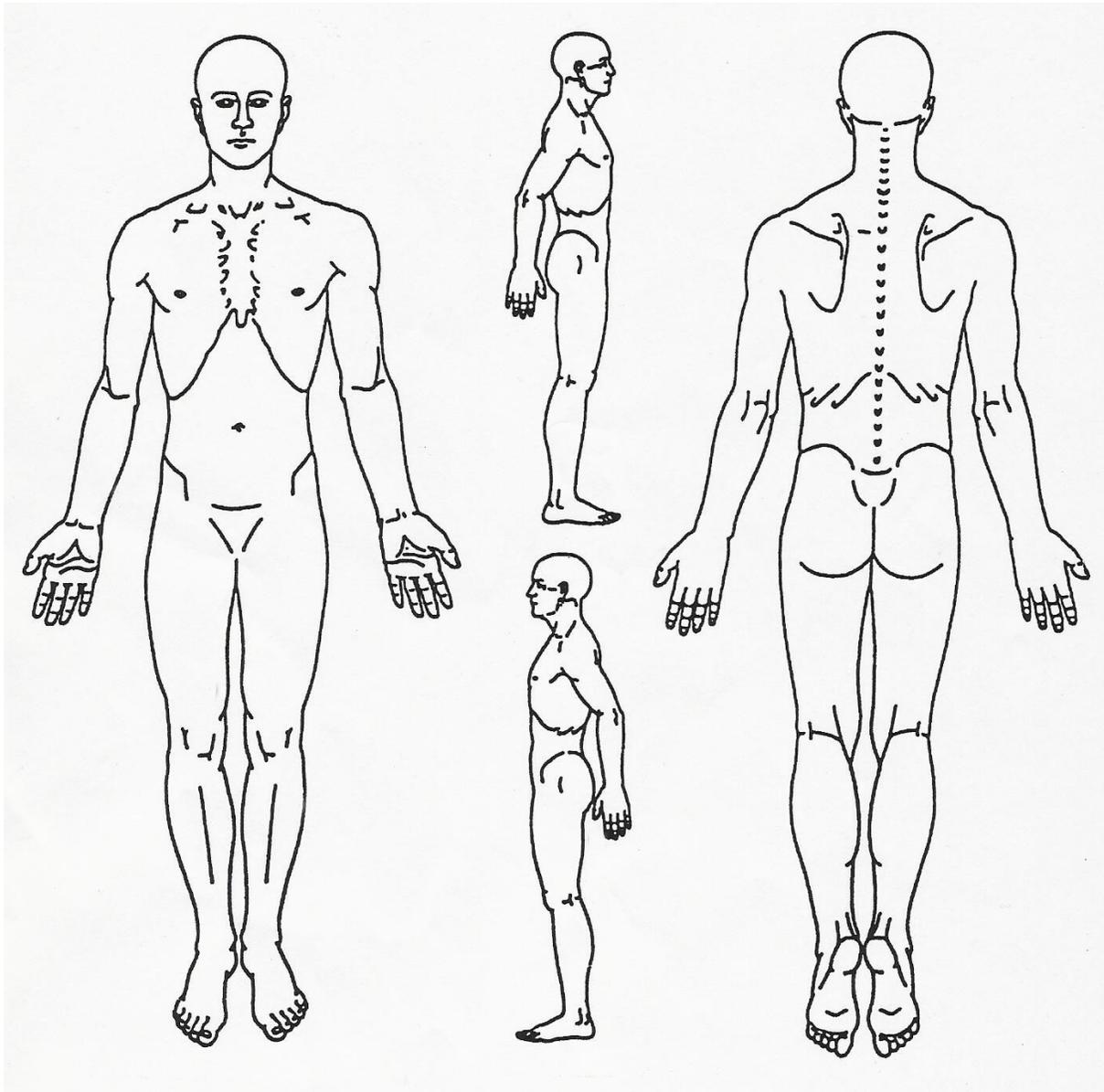
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PAIN DIAGRAM

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: oooooooooo



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

- | | | | |
|------------|------------------------|------------|------------------------|
| Neck: | 0 1 2 3 4 5 6 7 8 9 10 | Back: | 0 1 2 3 4 5 6 7 8 9 10 |
| Right arm: | 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 arm: | 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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NECK DISABILITY INDEX

Please complete this questionnaire. It is designed to give us information as to how your neck 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

- I can look after myself normally without causing extra neck pain.
- I can look after myself normally, but it causes extra neck pain.
- 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. I wash with difficulty and stay in bed.

3. Lifting

- I can lift heavy weights without extra neck pain.
- I can lift heavy weights but it gives me extra neck pain.
- Neck pain prevents me from lifting heavy weights off 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. Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want to with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read at all because of neck pain.

5. Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

6. Concentration

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty in concentrating.
- I have a great deal of difficulty concentrating.
- I cannot concentrate at all.

7. Work (or Housework)

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

8. Driving

- I can drive my car without neck pain.
- I can drive my car with only slight neck pain.
- I can drive my car as long as I want with moderate neck pain.
- I can't drive my car as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.

9. Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

10. Recreation

- I am able to engage in all my recreational activities with no neck pain.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my recreational activities because of my neck pain.
- I am able to engage in a few of my recreational activities because of neck pain.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.