AdventHealth
Shawnee Mission

# Patient Assessment Form

***(Please fill out this form and bring it with you to your appointment.)***

Name_____ Date of Birth: _____ Todays Date: _____

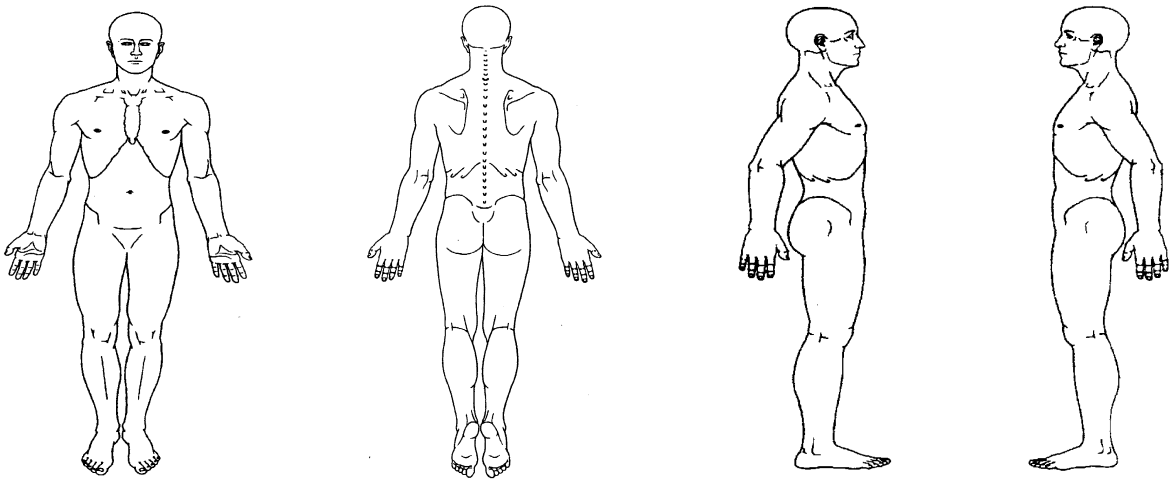
Age_____ Sex: M _____ F _____ Height: _____ft. _____ in. Weight _____ lbs.

Primary Physician _____

Referring Physician (If Different): _____

## CURRENT PROBLEM

**Please draw where your primary pain is located using the diagrams below:**



**When did the pain begin?** _____

**Did it begin gradually or suddenly?** _____**If suddenly, is it the result of an injury?** _____**Yes** _____**No**

**If result of an injury, describe the injury**_____

**If not a result of injury, what do you think caused your pain?** _____

_____

**Since your pain started is it (circle one)** **Worse** **Unchanged** **Intermittent** **Better** **N/A**

**Please describe your pain in as much detail as possible** _____

_____

_____

**Do you have any other symptoms such as numbness, weakness, or pins and needles sensation? Please describe.**

_____



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## CURRENT PROBLEM CONTINUED...

**What makes your pain worse? Standing_____ Sitting_____ Walking_____ Lying Down_____**

**Other_____**

**What have you found that makes your pain better? _____**

**Does your pain affect your sleeping? Yes_____ No_____ If so, how?_____**

**Do you have difficulty controlling your bowels? Yes _____ No_____ Difficulty controlling your bladder Yes_____ No_____**

**Please mark your average (A) and maximum (M) pain level on the line below.**

**0 1 2 3 4 5 6 7 8 9 10**
**No Pain ____I_____I_____I____I____I____I____I____I____I____I____I____ Worst Pain Imaginable**

**Was the injury work-related? Yes_____ No_____ Are you involved in a lawsuit? Yes _____ No_____**

**Does the pain interfere with your ability to work? Yes_____ No_____**

**If so, how? _____**

**Does the pain interfere with your daily activities? Yes_____ No_____**

**If so, how? _____**

**Do you need assistance with walking? Yes_____ No_____ Assistive Device? _____**

**If yes, is this assistive device preventing falls?**

**Have you had any recent falls? ___Yes ___No**

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## SUBJECTIVE ASSESSMENT OF THE HOME ACTIVITY LEVEL

***Please indicate which activities of daily living cause the greatest difficulty***

| PERSONAL | | HOUSEHOLD CHORES | | GENERAL MOBILITY | |
|---|---|---|---|---|---|
| Dressing upper body | _____ | Meal preparation | _____ | Sitting | _____ |
| Dressing lower body | _____ | Shopping | _____ | Bending | _____ |
| Bathing | _____ | Home Repairs | _____ | Getting in/out of bed | _____ |
| Hair care | _____ | House cleaning | _____ | Standing | _____ |
| Sleeping | _____ | Shoveling snow | _____ | Walking | _____ |
| Yard work/gardening | _____ | Twisting | _____ | Lifting | _____ |
| Child Care | _____ | Up and Down Stairs | _____ | Getting in/out of car | _____ |

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## HISTORY OF TREATMENTS

**Please indicate whether or not you have had any of these tests for your present problem:**

| | YES | NO | WHEN | WHERE |
|---|---|---|---|---|
| REGULAR X-RAYS | ☐ | ☐ | | |
| CT SCAN | ☐ | ☐ | | |
| MYLEOGRAM | ☐ | ☐ | | |
| MRI | ☐ | ☐ | | |
| BONE SCAN | ☐ | ☐ | | |
| BLOOD TESTS | ☐ | ☐ | | |
| EMG (nerve test) | ☐ | ☐ | | |
| DISCOGRAM | ☐ | ☐ | | |

**Please indicate the following treatments you have tried in the past.**

| TREATMENTS | DATE | BETTER | | OUTCOME | NA |
|---|---|---|---|---|---|
| | | yes | no | | |
| Exercise | | | | | |
| Physical Therapy | | | | | |
| Occupational Therapy | | | | | |
| Chiropractic | | | | | |
| Counseling | | | | | |
| Biofeedback | | | | | |
| Injections/Nerve Block | | | | | |
| TENS Unit | | | | | |
| Medications | | | | | |
| | | | | | |

## HISTORY OF PAST PROVIDERS

**Please list the names of all physicians, chiropractors, psychiatrist, psychologist, osteopaths, or other pain facilities whom you have seen for your present problem. List them in the order in which you saw them from first to last.**

| NAME OF PHYSICIAN | SPECIALTY | DATE FIRST SEEN | DATE LAST SEEN |
|---|---|---|---|
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## PAST MEDICAL HISTORY

**Do you have, or have you had any of the following conditions? (Please Check All That Apply)**

***ENDOCRINE***
__Diabetes
__Hypo/Hyperthyroid

***HEMATOLOGY***
__Bleeding disorder
__Anemia

***RHEUMATOLOGY***
__Arthritis, Type_____
__Fibromyalgia

***CARDIAC***
__Heart Attack
__Congestive Heart failure
__Coronary Artery Disease
__Valvular heart Disease
__High Blood Pressure

***GENITOURINARY***
__Incontinence
__Bladder control problems
__Kidney disease
__Kidney infections

***GASTROINTESTINAL***
__Ulcers
__Gallstones
__Liver Disease
__Hepatitis
__Pancreatitis
__GERD/reflux disease

***OTHER***
Cancer, Type _____
_____
_____
_____
_____

***RESPIRATORY***
__Asthma
__Bronchitis
__Emphysema/COPD

***NEUROLOGICAL***
__Stroke/TIA
__Migraines

***PSYCHIATRIC***
__ Bipolar disease
__ Depression
__ History of Drug/Alcohol problems
__ Other mental illness_____
__ Anxiety

**Please provide any additional about the above conditions below, or list other conditions not covered on the above list:**

_____

_____

_____

## PAST SURGICAL HISTORY

**Please list any surgeries you have had including procedure and date:**

| Surgery | Year | Facility/Physician |
|---|---|---|
| | | |
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# Patient Assessment Form

**CURRENT MEDICATIONS**

***ARE YOU TAKING ANY BLOOD-THINNING MEDICATIONS*? (e.g. ASPIRIN, COUMADIN, HEPARIN, TICLID, PLAVIX (CLOPEDIGREL) PLETAL, LOVENOX, ARISTA, JANTOVEN, WARFARIN, OTHER _____ YES_____ NO_____**

**Please list any medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers.**

| Medication & Dose | How often | Medication & Dose | How often |
|---|---|---|---|
| 1) | | 10) | |
| 2) | | 11) | |
| 3) | | 12) | |
| 4) | | 13) | |
| 5) | | 14) | |
| 6) | | 15) | |
| 7) | | 16) | |
| 8) | | 17) | |
| 9) | | 18) | |

**DRUG ALLERGIES**

**DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO If yes, please list the medication and the reaction:**

**This includes: medications, food, latex, iodine, environmental agents or irritants**

| Item/Drug | Reaction | Item/Drug | Reaction |
|---|---|---|---|
| | | | |
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## REVIEW OF SYSTEMS

**Do you have any of the following symptoms? Please circle all that apply.**

- ***GENERAL***: Weight loss, rashes, itching, color changes, headaches, dizziness, fever or chills, night sweats
- ***EYES***: Blurred vision, light sensitivity, deficits in your vision, changes in your vision.
- ***EAR,NOSE,THROAT***: Sinus problems, trouble swallowing, ringing in your ears, dental problems.
- ***CARDIAC***: Chest pain, palpitations, poor circulations, swelling in extremities, poor exercise tolerance
- ***REPIRATORY***: Shortness of breath, difficulty breathing, wheezing, coughing, sputum production.
- ***URINARY***: Painful urination, difficulty urinating, bladder control problems, frequent urinary infections.
- ***GASTROINTESTINAL***: Heartburn, nausea, vomiting, diarrhea, bloody stools, constipation.
- ***MUSCULOSKELETAL***: Achy swollen joints, stiff joints, muscle spasms, sore/ tender muscles.
- ***SKIN***: Rashes, skin irritations, skin ulcers.
- ***NEUROLOGICAL***: Poor memory, headaches, poor balance, loss of consciousness, fainting, muscle weakness, numbness, or changes in sensation.
- ***PSYCHOLOGICAL***: Anxiety, depression, increased emotional stress, hallucinations, paranoia, suicidal ideations (thoughts of harming yourself difficultly with concentration.
- ***ENDOCRINE***: Always thirsty, always hot, always cold, hair and nail changes.
- ***HEMATOLOGY***: Easy bruising, cuts take a long time to stop bleeding, painful lymph nodes, frequent leg swelling, fatigue.
- ***ALLERGIC/IMMUNE***: are you prone to infections, sensitive to many foods, medicines

## FAMILY HISTORY

**Please list any significant medical problems for any blood relatives(parents, grandparents, brothers or sisters) also list any medical problems that tends to run in your family.**

_____

_____

_____

## SOCIAL HISTORY

**Marital Status: Single___ Married_____ Divorced_____ Widowed_____**

**Indicate current household members: Self_____ Spouse_____ Children_____ Other_____**

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**What kind of support do you have to help you cope with this problem? (e.g. family, friends, church, etc.)**

_____

**EXERCISE: Type of exercise:**_____

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# Patient Assessment Form

Days/Week:_____

TOBACCO USE: Do you currently use tobacco products? ____Yes ____NO

IF YES, how many packs a day? _____ How many years?_____

IF FORMER SMOKER, when did you quit? _____ before you quit, how many packs a day _____ and how many years_____

Do you drink caffeinated beverages? ☐ YES ☐ NO If yes, how many cups/cans per day? _____

Do you drink alcoholic beverages? ☐ YES ☐ NO If yes, how many beverages per week? _____

Have you ever had, or do you have a substance abuse problem? Yes___ No___

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Are you currently employed? ___Yes ___No. If yes, please complete the following questions:

Your current employer _____

Your current occupation _____

Your usual duties include: _____

Are you involved with Workman's compensation? ____Yes ____No

If so, what is the name and phone number of your case worker? _____

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## OTHER

**Is there any chance you could be pregnant? ☐ YES ☐ NO If yes, when is your due date?**

Primary Language: ☐ English ☐ Spanish ☐ Other_____ Do you need an interpreter? ☐ YES ☐ NO

Are you hard of hearing? ☐ YES ☐ NO Do you need glasses to read? ☐ YES ☐ NO

Would you like to have a consult with a dietician to discuss any dietary concerns? ☐ YES ☐ NO

Are there any religious or cultural factors which may impact your care while in the clinic? ☐ YES ☐ NO

If yes, please explain_____

Do you, or anyone you know, need information regarding problems of abuse and/or neglect? Yes _____ No _____

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What are your realistic goals for treatment of your pain? (check all that apply)

To be pain free _____ Help living with pain _____ Other _____

Reduced pain _____ Increased activity _____

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Thank you for your time in completing this form

Patient signature: Date:

_____ _____