James Powers, MD
Robert Perkins, MD
Emliy Yu, MD

PHYSICAL MEDICINE ASSOCIATES, INC.

Jeffrey Strakowski, MD
Jonathan Pedrick, MD

New Patient Questionnaire

Name_____Date of Birth_____Age _____Today's Date_____

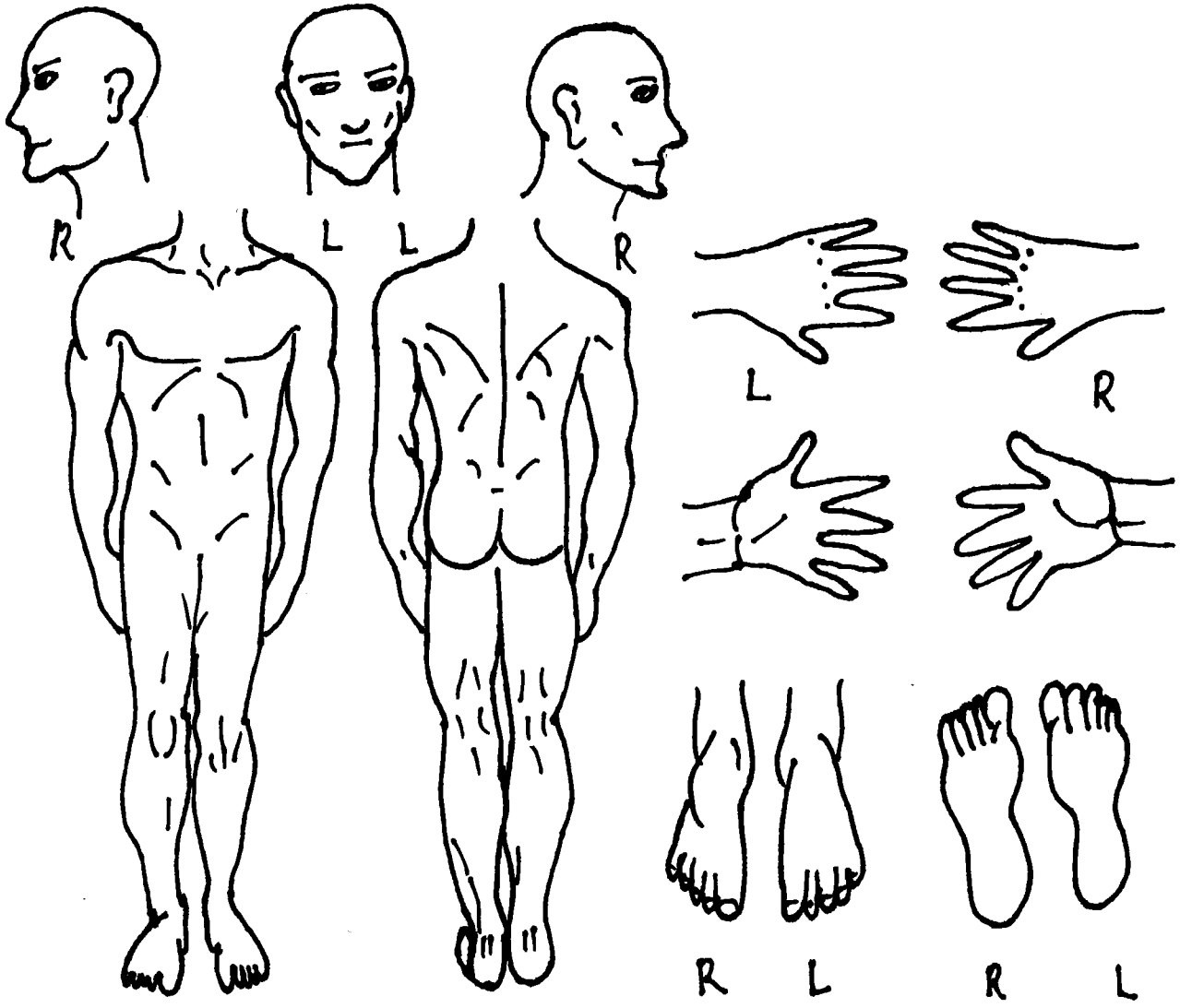
Referring Physician: _____

Are you: Right handed _____ Left handed _____ Height _____ Weight _____

HISTORY OF PRESENTING ILLNESS

Primary Problem_____
Where is your pain located?_____

Please mark the figure with the location of your symptoms: Pain = XX Numbness/Tingling = 00



Describe how and when pain began _____

_____

Describe your pain (check all that apply): sharp___ burning___ achy___ knife-like___
Twisting___ Pressure___ lancinating___ deep___ heavy___ gnawing___ tooth-ache___
Other (describe)_____

Check the activities that are painful or difficult to do:

☐ sitting	☐ walking	☐ bending	☐ reaching overhead
☐ computer	☐ standing	☐ twisting	☐ sleeping
☐ stairs	☐ housekeeping	☐ driving/car riding	☐ squatting down
☐ other _____			

What helps relieve the pain? _____

Please check any of the following treatments you have had relative to this condition:

☐ Physical Therapy	☐ Psychologist	☐ Pain program	☐ Nerve Ablation
☐ Occupational Therapy	☐ Chiropractor	☐ Nerve Block / Epidural	☐ Spinal Cord Stimulator
☐ Massage	☐ TENS unit	☐ SI Joint Injection	☐ Water Therapy
☐ Acupuncture	☐ Surgery	☐ Facet Injection	

Did any of these help? _____

Did any of these make it worse? _____

Have you had any diagnostic tests performed? (MRI, CT-scans, EMG, X-ray, Myelogram, Bone Scan, etc.) Yes_____
No _____ If yes, please list:

_____

Females, is there a possibility you are pregnant? ☐Yes ☐No

Please fill in the PAIN SCALE with **0 being pain-free and 10 being the worst pain possible.**

Average pain over the past week:

0 1 2 3 4 5 6 7 8 9 10
No Pain — Distressing Pain — Unbearable Pain

Peak pain over the past week:

0 1 2 3 4 5 6 7 8 9 10
No Pain — Distressing Pain — Unbearable Pain

PRESCRIPTION MEDICATIONS (FOR VITAMINS AND SUPPLEMENTS - SEE CHECK BOXES BELOW)

Name of Drug	Dose	Times per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

Please check the over the counter medications and vitamin/herbal supplements you take daily.

☐ Aspirin ☐ Vitamins/Minerals ☐ Glucosamine/Chondroitin ☐ Herbals

OTHER ALLERGIES (please list additional allergies here):

_____

_____

PHYSICAL ACTIVITY

1. Circle the number of days per week you accumulate 30 minutes of daily activity such as walking, climbing stairs, raking leaves, or vacuuming/sweeping? None 1 2 3 4 5 6 7
2. Circle the number of days per week you engage in cardiovascular (aerobic) exercise of at least 20-30 minutes duration such as brisk walking, cycling, jogging, swimming, etc? None 1 2 3 4 5 6 7
3. Are you involved in any recreational sports or activities? Please list: _____
4. Please list activities you would like to perform if your pain improves: _____

_____

WORK HISTORY:

Occupation: _____ Employer: _____ How long in position? _____

Please describe your job duties:

_____

Are you working? ☐ No Date last worked: _____

☐ Yes Full-time: _____ Part-time: _____

Job Restrictions: ☐ No ☐ Yes If yes, please describe _____

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Name_____

Date of Birth_____

Please **fill in** the circle beside each item completely.

Family History:

Adopted o

	Mother	Father	Sister	Brother
Medical History Unknown	o	o	o	o
Alive	o	o	o	o
Cardiovascular Disease (Heart Disease)	o	o	o	o
Diabetes	o	o	o	o
Hypertension (High Blood Pressure)	o	o	o	o
Hyperlipidemia (High cholesterol)	o	o	o	o
Stroke	o	o	o	o
Breast Cancer	o	o	o	o
Colon Cancer	o	o	o	o
Lung Cancer	o	o	o	o
Osteoporosis	o	o	o	o
Arthritis	o	o	o	o
Other	o	o	o	o

Social History:

Single o
Married o
Life Partner o
Divorced o
Separated o
Widow o

(Fill in circle if the answer is YES)

You drink more than two alcoholic drinks per day o
You smoke tobacco o
You quit smoking/tobacco use (you were a previous smoker/tobacco user) o
You use recreational drugs o
You have ever been addicted to drugs or alcohol o
You have had a family member that is/was addicted to drugs or alcohol o

You are currently working o
You are disabled o
You have current job restrictions o

Allergies:

Allergies to medications: (please list others on separate page)

Penicillin o
Sulfa antibiotics o
Amoxicillin o
Lidocaine o
Latex o
No known allergies to medications o

Allergy to IV contrast dye:

Yes o
No o
Unknown o

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Please **fill in** the circle beside each item completely.

Past Medical History:

Cardiovascular:

- Heart Attack o
- Angina o
- Heart Valve Disease o
- Hypertension o
- High Cholesterol o
- Atrial fibrillation o
- Congestive Heart Failure o
- Stroke o
- TIA (mini stroke) o
- Carotid Blockage o
- Claudication o
- Peripheral Vascular Disease o
- Abdominal Aneurysm o
- DVT (blood clot) o

Pulmonary:

- Asthma o
- Emphysema o
- COPD o
- Pneumonia o
- Pulmonary Hypertension o
- Lung Cancer o
- Tuberculosis o
- Chronic Bronchitis o
- Pulmonary Embolism o

Psychosocial:

- Depression o
- Stress o
- Anxiety o
- PTSD o
- Panic Attacks o
- Bipolar disorder o
- Prior TBI (head injury) o
- Other o

Musculoskeletal:

- Concussion o
- Rheumatoid Arthritis o
- Osteoarthritis o
- Osteopenia o
- Osteoporosis o
- Low Back Pain o
- Fibromyalgia o
- Myofascial Pain o
- Chronic Fatigue Syndrome o
- Rotator Cuff Disorder o
- Carpal Tunnel Syndrome o
- Neuropathy o
- Herniated Disc in Neck o
- Herniated Disc in Lumbar Spine o
- Sciatica o
- Lumbar Stenosis o
- Spasticity o

Other:

- Thyroid Disease o
- Diabetes o
- GERD (reflux) o
- Stomach Ulcer o
- Prior GI Bleed o
- Inflammatory Bowel Disease o
- Irritable Bowel Disease o
- Bowel Polyps o
- Hepatitis o
- Cirrhosis (Liver Disease) o
- Renal Insufficiency (Kidney Disease) o
- Dialysis o
- Multiple Sclerosis o
- Parkinson's Disease o
- Seizures o
- Breast Cancer o
- Prostate Cancer o
- Colon Cancer o
- Lung Cancer o
- Lymphoma o
- Leukemia o
- Other Cancer o
- Chemotherapy o
- Radiation o
- HIV/AIDS o
- Other o

Surgical History:

- C-section o
- Hysterectomy o
- Cholecystectomy (gallbladder removal) o
- Tonsillectomy (tonsil removal) o
- Pacemaker/defibrillator o
- CABG (heart bypass surgery) o
- Angioplasty to legs o
- Bypass surgery to legs o
- Heart valve surgery o
- Heart stent placement o
- Knee replacement o
- Knee surgery/scope o
- Hip replacement o
- Hip surgery/scope o
- Fracture repair o
- Neck surgery o
- Back surgery o
- Shoulder surgery/scope o
- Carpal tunnel surgery o
- Other o

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Name_____

Have you had any of the following symptoms over the past month?
If YES, Please **fill in** the circle beside the symptom completely.

Date of Birth_____

Constitutional:
- Weight gain O
- Weight loss O
- Fever O
- Chills O
- Weakness O
- Night sweats O

Cardiovascular:
- Elevated BP O
- Dizzines O
- Chest pain O
- Heart pounding O
- Palpitations O
- Leg swelling O
- History of rheumatic fever O

Respiratory:
- Cough O
- Wheezing O
- Change in exercise tolerance O
- Shortness of breath O
- Bronchitis O

Endocrine:
- Excess sweating O
- Feeling cold all of the time O
- Feeling hot all of the time O
- Excess thirst O
- Excess hunger O
- Thyroid trouble O
- Diabetes O

Ear, Nose and Throat:
- Ringing in ears O
- Sinus pain O
- Sneezing O
- Change in hearing O
- Vertigo O
- Colds O
- Sore throat O
- Dentures O

Hematologic/Oncology:
- Bleeding problem O
- Easy bruising O
- Blood clots O
- Anemia O
- Transfusion reactions O
- History of cancer O

Gastrointestinal:
- Nausea O
- Vomitin O
- Heartburn O
- Abdominal pain O
- Difficulty swallowing O
- Diarrhea O
- Constipation O
- Blood in stool O
- Indigestion O
- Difficulty controlling bowels O

Genitourinary:
- Difficulty urinatin O
- Blood in urine O
- Frequent urinatio O
- Incontinence O
- Frequent urination at night O
- Sexual problems O
- Pregnant O

Psychological:
- Insomnia O
- Memory concern O
- Irritability O
- Feeling down or depressed O
- High stress level O
- Anxiety or nervousness O
- Suicidal ideation O
- Mood changes O

Skin:
- Rash O
- Itching O
- Dryness O
- Jaundice O
- Hair changes O
- Nail changes O
- Easy bruising O
- Lumps O

Eyes:
- Blurred vision O
- Double vision O
- Cataracts O
- Light sensitivity O
- Wear glasses or contacts O
- Tearing O

Neurological:
- Seizures O
- Paralysis O
- Numbness O
- Tingling O
- Fainting O
- One sided weakness O

Musculoskeletal:
- Joint inflammation (pain, redness, swelling) O
- Morning stiffness O
- Muscle pain O
- Neck pain O
- Back pain O
- Trauma O
- Weakness O
- Cramps O
- Arm or leg pain O