RUSH
Castle Orthopaedics

Patient Health Questionnaire

IDN13150147

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ESTABLISHED PATIENT HEALTH HISTORY

Name: _____ Age: _____ Date of Visit: _____

Email: _____ DOB:_____ MR#: _____

Primary Care Provider: _____ Height: ____ ft ____in Weight: _____ lbs

Referred by: ☐ Physician _____ ☐ Therapist ☐ Athletic Trainer ☐ Chiropractor ☐ None

How did you hear about us: ☐ Internet ☐ Advertisement ☐ Family Member

☐ Friend ☐ Primary Provider ☐ Other _____

Pharmacy Name and Location : _____

_____

CHIEF COMPLAINT

Why are you here today? _____

_____

Which side is affected: ☐ Right ☐ Left ☐ Both

If it involves your hand which fingers: ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Small

Dominant Hand: ☐ Right ☐ Left ☐ Both

How long have you been experiencing these symptoms? _____

Did your problem result from a specific injury or accident? ☐ Yes ☐ No ☐ Workman's Compensation ☐ Auto

Date of Injury_____ Describe the injury or accident: _____

_____

For Clinical Staff: HT _____ WT _____ BP _____ HR _____

How bad is the pain on a 0 – 10 scale?

O	O	O	O	O	O	O	O	O	O	O
0	1	2	3	4	5	6	7	8	9	10

MILD WORST

HISTORY OF PRESENT ILLNESS (Check all that apply)

Symptoms: ☐ Pain ☐ Redness ☐ Swelling ☐ Bruising ☐ Stiffness ☐ Weakness ☐ Tingling

☐ Numbness ☐ Deformity ☐ Other: _____

Location: Does the problem go to other areas? ☐ Yes ☐ No If yes, where? _____

Quality: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Shooting

Severity: ☐ Mild ☐ Moderate ☐ Severe

Onset: ☐ Gradual ☐ Recurrent ☐ Sudden

Timing: ☐ Occasional ☐ Intermittent ☐ Constant ☐ With Activity ☐ At Rest ☐ Morning ☐ At Night

Context: What are you doing when the symptoms occur?_____

Can you reproduce the symptoms? ☐ Yes ☐ No

Modifying Factors: What has made it better? _____

☐ Rest ☐ Ice ☐ Heat ☐ Over the Counter Medications ☐ Prescription Medication

What has made it worse? _____

☐ Pain increases with cough or sneezing

Prior Treatment for this? ☐ Yes ☐ No

By Whom: ☐ Primary Provider ☐ Emergency Room ☐ Another Orthopedist ☐ Chiropractor

☐ Pain Provider ☐ Rheumatologist

Form of Treatment: ☐ Medication ☐ Therapy ☐ Splinting/Casting ☐ Injection ☐ Surgery

Other Tests: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ EMG / Nerve Testing

☐ Myelogram

Patient Name: _____ **DOB:** _____

☐ **CHANGES SINCE LAST VISIT**

Allergies ☐ None

☐ Penicillin ☐ Keflex ☐ Sulfa ☐ Contrast / Dye

☐ Aspirin ☐ NSAIDS ☐ Latex ☐ Metal/jewelry

☐ Shellfish ☐ Other: _____

Pharmacy Name and Location:

_____

_____

New Medications: ☐ None

Name: _____ Dose: _____ Frequency: _____ Last Taken: _____

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REVIEW OF SYSTEMS (Check those that apply to you)

Constitution ☐ neg
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected Weight Gain/Loss

HENT ☐ neg
- ☐ Dental Problems
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Runny Nose
- ☐ Sinus Pain
- ☐ Sore Throat

Eyes ☐ neg
- ☐ Eye Pain
- ☐ Visual Disturbance

Respiratory ☐ neg
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular ☐ neg
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations

GI ☐ neg
- ☐ Abdominal Pain
- ☐ Blood In Stool
- ☐ Nausea
- ☐ Vomiting

Endocrine ☐ neg
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Urination

GU ☐ neg
- ☐ Difficulty Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urgency

Musc ☐ neg
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Neck Pain

Skin ☐ neg
- ☐ Rash
- ☐ Wound

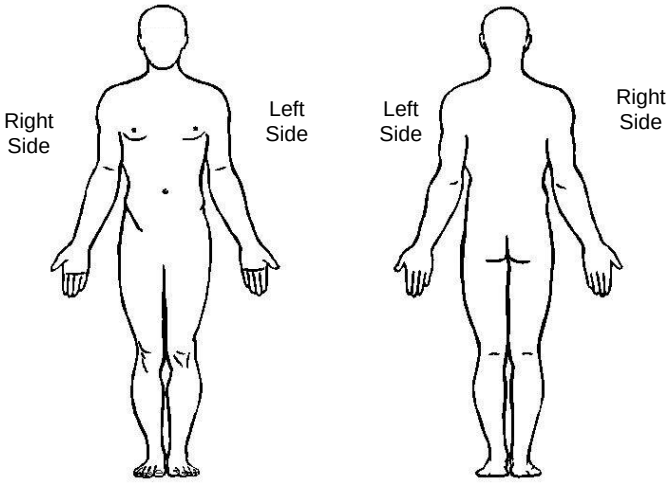
Allergy/Immunization ☐ neg
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurological ☐ neg
- ☐ Dizziness
- ☐ Headache
- ☐ Light Headache
- ☐ Numbness
- ☐ Seizure
- ☐ Tremors
- ☐ Weakness

Hematosis ☐ neg
- ☐ Agitation
- ☐ Confusion
- ☐ Depression
- ☐ Sleep Disturbance
- ☐ Suicidal Ideas

Mark the area or region on the diagram where you have any of the following sensations:

Ache	Numbness	Pins & Needles	Stabbing	Burning	Shooting
^ ^ ^	O O O	X X X X	/ / /	# # #	? ? ?



I certify that to the best of my knowledge the above information is correct.

Signature of Patient or Parent/Legal Guardian: _____

Date: _____ Time: _____