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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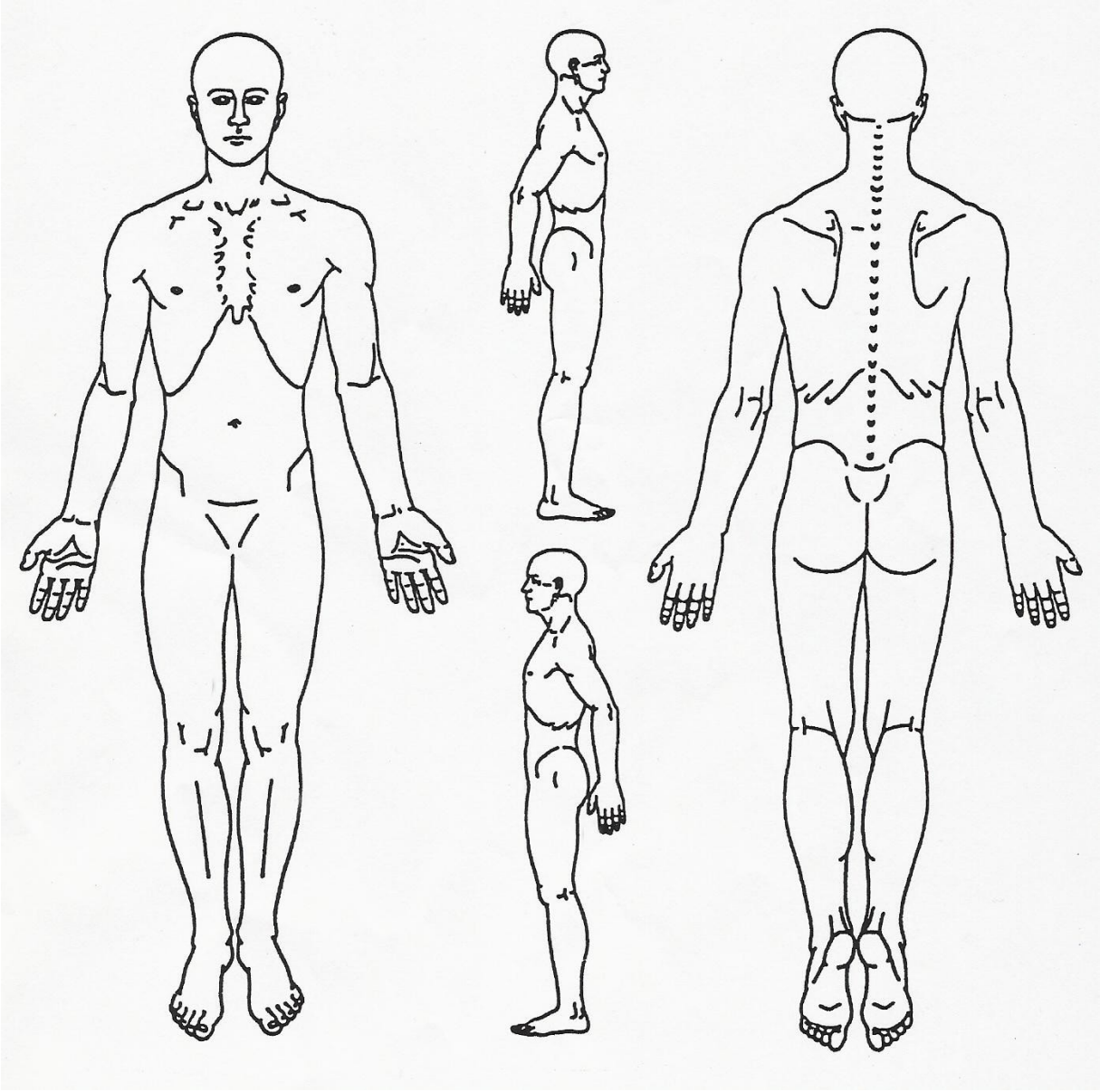
PAIN DIAGRAM

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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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.