RUSH

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.		
Pharmacy (Name, Address, Phone #):		

PRESENT PROBLEM

What is your primary complaint?
When did it begin?
What caused it?
What makes it worse?
What makes it better?
Any related symptoms?
Is this a work-related problem? Date of accident?
Anything else we should know?

TREATMENTS (in the last **ONE** year)

❑ **Oral Steroids**
Length of Treatment: _____ weeks
❑ Improved symptoms ❑ Unchanged

❑ **NSAID's** (e.g. Ibuprofen, Advil, Meloxicam, etc.)
Length of Treatment: _____ weeks
❑ Improved symptoms ❑ Unchanged

❑ **Epidural Steroid Injections**
Dates: _____
❑ Improved symptoms ❑ Unchanged ❑ Worse

❑ **Facet Injections and/or Ablations**
Dates: _____
❑ Improved symptoms ❑ Unchanged ❑ Worse

❑ **Physical Therapy**
From _____ to _____
Total Sessions: _____
❑ Improved symptoms ❑ Unchanged ❑ Worse

❑ **Massage**

❑ **Home Exercises**

❑ **Chiropractor**

❑ **Acupuncture**

❑ **Other treatments:**

_____

_____

_____

MEDICAL HISTORY

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Medical Problems
❑ Diabetes
❑ Hypertension
❑ High Cholesterol
❑ Thyroid Disease
❑ Anxiety
❑ Depression
❑
❑
❑

Surgeries (please include year and hospital)

Medications and Doses (e.g. Aspirin 81 mg daily)
❑ List attached

Allergies and Reactions (e.g. Penicillin – rash)
❑ No known allergies

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 ❑ Unemployed
Tobacco: ❑ Never smoked ❑ Quit smoking _____ years ago ❑ Currently smoke ____ packs/day for ____ years ❑ Use smokeless tobacco (e.g. chew) ❑ Vape	**Alcohol:** ❑ Never drank alcohol ❑ Quit drinking _____ years ago ❑ Currently drink _____ alcoholic drinks per week	**Drugs:** ❑ Never used drugs ❑ Quit using drugs _____ years ago ❑ Currently use recreational/street drugs (e.g. marijuana, LSD, heroin, etc.) Drug(s): _____ How often? _____

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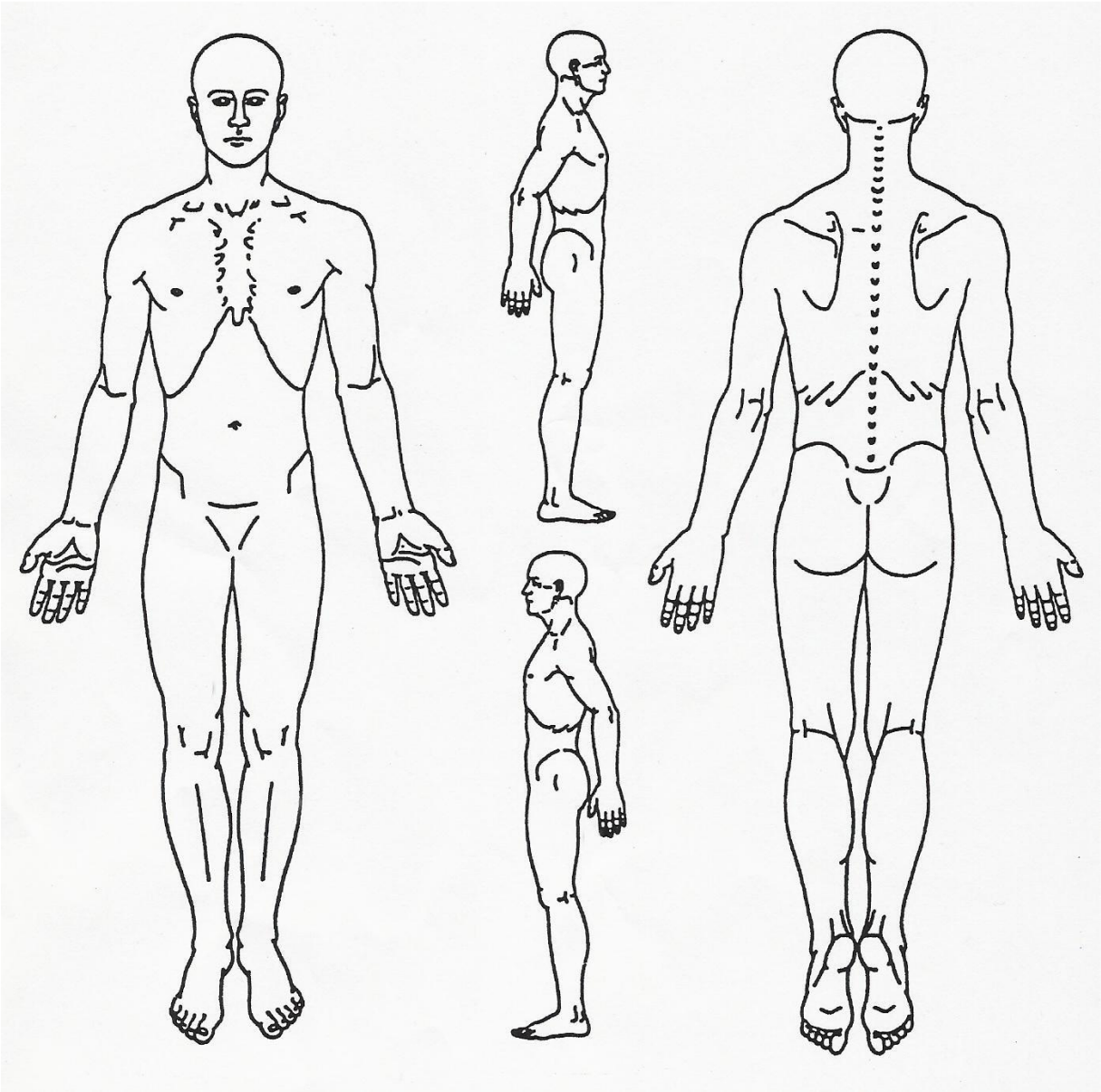
PAIN DIAGRAM

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 **Back: 0 1 2 3 4 5 6 7 8 9 10**