Rehabilitation Institute of Washington, PLLC
New Patient Questionnaire

Name: _____ Date: _____

Age: _____ Are you **Right** or **Left**-handed? _____

Referring MD: _____ Primary MD: _____

Present Problem: _____

_____

When did it start? _____ Is it a work related injury? _____ Date last worked: _____

Have you been evaluated or treated for this problem? _____ By whom? _____

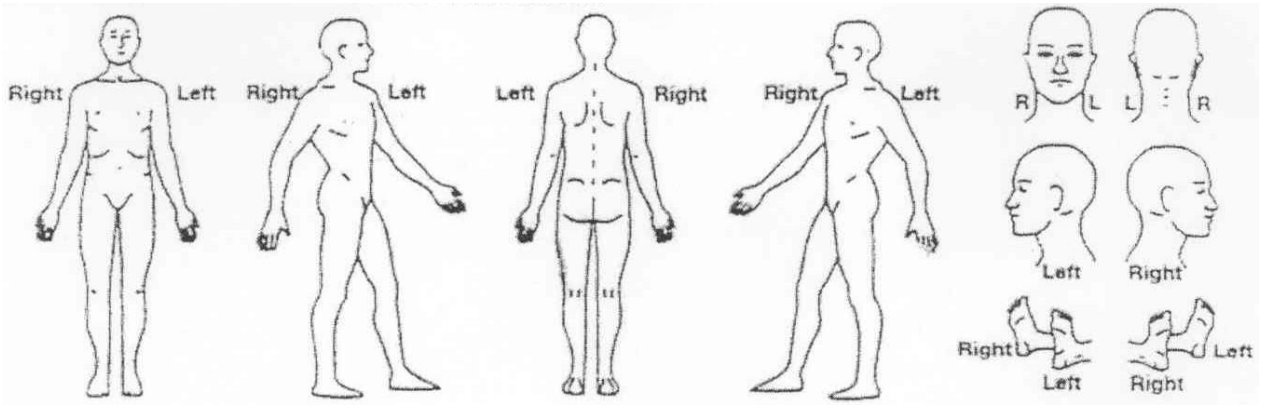
Have you had any **diagnostic studies**? Please indicate when and where the studies were done, and the results.

☐ X-rays When? _____ Where? _____ Result: _____
☐ MRI When? _____ Where? _____ Result: _____
☐ CT scan When? _____ Where? _____ Result: _____
☐ Bone scan When? _____ Where? _____ Result: _____
☐ EMG When? _____ Where? _____ Result: _____

Have you had any **treatment** for this problem? Surgery Therapy Injections Chiropractic Medications

Other (describe) _____

LOCATION OF PAIN (Shade in affected areas)



On average, how would you rate your pain during the last week?

0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

On average, how much does pain interfere with your ability to do your usual daily activities?

0 1 2 3 4 5 6 7 8 9 10

I can do all usual activities Unable to do any usual activities

Circle the number that best describes how **worried** you are about your pain.

0 1 2 3 4 5 6 7 8 9 10

No worry Extreme worry

Patient:_____
Clinic #:_____

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Past Medical History: Please list all chronic, ongoing or major past medical problems.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Surgical History: Please list any surgeries you have had with the date of surgery.

_____ _____

_____ _____

_____ _____

_____ _____

Review of Systems: Please check all that apply.

General:
____Fever
____Night sweats
____Chills
____Fatigue
____Weight change
Up_____ Down____ #_____

Eyes:
____Blurred/double vision
____Loss of vision
____Glasses/contacts
____Dry eyes

Ear, Nose, Throat:
____Hearing loss
____Loss of taste
____Nasal congestion
____Nasal discharge
____Choking
____Hoarseness
____Sore throat
____Dry mouth

Respiratory:
____Cough
____Shortness of breath
With exertion?____ lying flat?____

Cardiovascular:
____Chest pain
____High blood pressure
____Calf pain with walking
____Leg swelling

Gastrointestinal:
____Abdominal pain
____Indigestion
____Nausea
____Vomiting
____Constipation
____Diarrhea
____Bowel incontinence

Genitourinary:
____Urinary frequency/urgency
____Urinary burning
____Bladder incontinence
____Erectile dysfunction
____Sexually active

Gynecological:
____Pregnant
____Abnormal vaginal bleeding
____Excessive menstrual pain
____Postmenopausal
____Vaginal dryness

Musculoskeletal:
____Back pain
____Neck pain
____Joint pain
Which joints_____
____Joint swelling
____Joint warmth/redness

Neurologic
____Fainting
____Numbness
____Seizures
____Tremors
____Weakness
____Headaches
____Problems with memory or concentration

Psychological
____Anxious/Nervous
____Irritability
____Change in appetite
____Change in sleep pattern
____Feelings of depression

Endocrine
____Diabetes
____Increased thirst
____Thyroid problems
____Excessive sweating
____Heat intolerance
____Cold intolerance

Hematologic
____Anemia
____Easy bruising or bleeding
____Previous transfusions

Skin
____Pressure sores
____Rash

Patient:_____
Clinic #:_____

Rehabilitation Institute of Washington, PLLC
New Patient Questionnaire

Social History:

Are you: ___ Single ___ Married ___ Separated ___ Divorced ____ Partnered? Any children? _____

Occupation:_____ Retired?___ Disabled?_____

Ethnicity:

What is your ethnic background?

_____White _____Black _____Hispanic _____Native American

_____Asian/Pacific Islander _____Other _____Prefer not to answer

Gender: Male_____ Female_____

Habits:

Tobacco: how much?_____how long?_____ Coffee: _____ Soda: _____

Do you drink alcohol? Yes____ No____

If so, how many drinks do you typically drink per day? _____ (Note: One drink is defined as one 12 oz. beer or wine cooler, one 5 oz. glass of wine, 1.5 oz. of 80-proof distilled spirits, as in a shot of liquor or a mixed drink)

Family History: (Please list medical problems that run in your family – e.g. diabetes, heart disease, cancer…)

Mother: _____

Father: _____

Siblings: _____

Medications: Dose Frequency Side effect?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies: (Please list all drugs you have had an allergic reaction to and what that reaction was.)

_____

_____

_____

Patient:_____

Clinic #:_____

Rehabilitation Institute of Washington, PLLC
New Patient Questionnaire

ACTIVITIES OF DAILY LIVING

Please indicate your level of independence with the following activities:

ACTIVITY	I DO ON MY OWN	I DO ON MY OWN, BUT SLOWLY	I NEED ASSISTIVE EQUIPMENT	I NEED HELP	SOMEONE ELSE DOES THIS FOR ME	N/A
Dressing, including foot wear						
Showering and bathing						
Toileting						
Cooking						
Dishwashing						
Vacuuming						
Other cleaning						
Grocery shopping						
Mowing the lawn						
Other yard work						
Outside household maintenance						

Do you DRIVE? Yes / No

If you do not drive, why not?

I do not have a license.
I do not have a car.
I find driving too painful or uncomfortable.
I do not feel safe driving because of medications.
Other reason?_____

How many hours out of a 24 hour day do you spend:

Lying down (in bed or on couch/recliner): _____
Sitting: _____
Standing or walking: _____

How much time can you walk before you have to stop because of pain or fatigue? _____

Patient:_____
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Rehabilitation Institute of Washington, PLLC
New Patient Questionnaire

EQUIPMENT

Please circle the pieces of equipment you have in your home for your use. Please indicate how often you use this equipment.

I USE THIS EQUIPMENT:	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
Cane					
Crutches					
Walker					
Wheelchair, manual					
Wheelchair, power or scooter					
Walking boot					
Braces or other Orthotics					
Raised toilet seat					
Grab bars					
Shower bench					
Hand held shower					

RECREATION

Please list recreational activities that you used to do, but can no longer do because of your injury:

_____

_____

_____

Please list recreational activities that you still participate in:

_____

_____

_____

Patient:_____

Clinic #:_____

Rehabilitation Institute of Washington, PLLC
New Patient Questionnaire

This questionnaire has been designed to give us information as to how your **pain** is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the spot that indicates the statement which **most clearly describes your problem**.

Section 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

Section 2: Personal Care (eg. washing, dressing)
□ I can look after myself normally without causing extra pain
□ I can look after myself normally but it causes extra pain
□ It is painful to look after myself and I am slow and careful
□ I need some help but can manage most of my personal care
□ I need help every day in most aspects of self-care
□ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
□ I can lift heavy weights without extra pain
□ I can lift heavy weights but it gives me extra pain
□ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table)
□ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
□ I can only lift very light weights
□ I cannot lift or carry anything

Section 4: Walking
□ Pain does not prevent me walking any distance
□ Pain prevents me from walking more than 1 mile
□ Pain prevents me from walking more than ½ mile
□ Pain prevents me from walking more than 100 yards
□ I can only walk using a stick or crutches
□ I am in bed most of the time

Section 5: Sitting
□ I can sit in any chair as long as I like
□ I can only sit in my favorite chair as long as I like
□ Pain prevents me sitting more than one hour
□ Pain prevents me from sitting more than 30 minutes
□ Pain prevents me from sitting more than 10 minutes
□ Pain prevents me from sitting at all

Section 6: Standing
□ I can stand as long as I want without extra pain
□ I can stand as long as I want but it gives me extra pain
□ Pain prevents me from standing for more than 1 hour
□ Pain prevents me from standing for more than 30 minutes
□ Pain prevents me from standing for more than 10 minutes
□ Pain prevents me from standing at all

Section 7: Sleeping
□ My sleep is never disturbed by pain
□ My sleep is occasionally disturbed by pain
□ Because of pain I have less than 6 hours sleep
□ Because of pain I have less than 4 hours sleep
□ Because of pain I have less than 2 hours sleep
□ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)
□ My sex life is normal and causes no extra pain
□ My sex life is normal but causes some extra pain
□ My sex life is nearly normal but is very painful
□ My sex life is severely restricted by pain
□ My sex life is nearly absent because of pain
□ Pain prevents any sex life at all

Section 9: Social Life
□ My social life is normal and gives me no extra pain
□ My social life is normal but increases the degree of pain
□ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
□ Pain has restricted my social life and I do not go out as often
□ Pain has restricted my social life to my home
□ I have no social life because of pain

Section 10: Traveling
□ I can travel anywhere without pain
□ I can travel anywhere but it gives me extra pain
□ Pain is bad but I manage journeys over two hours
□ Pain restricts me to journeys of less than one hour
□ Pain restricts me to short necessary journeys under 30 minutes
□ Pain prevents me from travelling except to receive treatment

Patient:_____
Clinic #:_____

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New Patient Questionnaire

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please check only one response.

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or Cannot Do
S1	Standing for long periods such as 30 minutes?					
S2	Taking care of your household responsibilities?					
S3	Learning a new task, for example, learning how to get to a new place?					
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?					
S5	How much have you been emotionally affected by your health problems?					
S6	Concentrating on doing something for ten minutes?					
S7	Walking a long distance such as a kilometer [or equivalent]?					
S8	Washing your whole body?					
S9	Getting dressed?					
S10	Dealing with people you do not know?					
S11	Maintaining a friendship?					
S12	Your day-to-day work?					
H1	Overall, in the past 30 days, how many days were these difficulties present? ***Record number of days ____***					
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition? ***Record number of days ____***					
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition? ***Record number of days ____***					

Patient:_____

Clinic #:_____

Rehabilitation Institute of Washington, PLLC
New Patient Questionnaire

Please indicate the extent to which you agree or disagree with the following statements.

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. I'm afraid that I might injure myself if I exercise.	_____	_____	_____	_____
2. If I were to try to overcome it, my pain would increase.	_____	_____	_____	_____
3. My body is telling me I have something dangerously wrong.	_____	_____	_____	_____
4. People aren't taking my medical condition seriously enough.	_____	_____	_____	_____
5. My accident has put my body at risk for the rest of my life.	_____	_____	_____	_____
6. Pain always means I have injured my body.	_____	_____	_____	_____
7. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.	_____	_____	_____	_____
8. I wouldn't have this much pain if there weren't something potentially dangerous going on in my body.	_____	_____	_____	_____
9. Pain lets me know when to stop exercising so that I don't injure myself.	_____	_____	_____	_____
10. I can't do all the things normal people do because it's too easy for me to get injured.	_____	_____	_____	_____
11. No one should have to exercise when he or she is in pain.	_____	_____	_____	_____

Patient:_____

Clinic #:_____

Rehabilitation Institute of Washington, PLLC
New Patient Questionnaire

Below is a list of the ways you might have felt or behaved. Please check the column to tell me how often you have felt this way during the past 2 weeks.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

Patient:_____
Clinic #:_____

Rehabilitation Institute of Washington, PLLC
New Patient Questionnaire

Education and Occupation

How many years of school have you completed:_____

Of the kinds of work listed below, use the corresponding numbers to answer questions 1-4:

1. Agriculture
2. Mining/Oil
3. Construction
4. Wholesale
5. Retail (food stores, automotive, general merchandise)
6. Transportation/Warehouse/Public Utilities
7. Finance/Insurance/Real Estate/Banking
8. Service (hotel, auto repair, health)
9. Manufacturing (lumber, stone, metals, canned food)

1. What kind of work were you doing when you were injured? (1-9) _____
2. What kind of work have you done most? (1-9) _____
3. What kind of work have you done since your injury? (1-9) _____
4. What other kinds of work have you done? (Use as many numbers as apply) _____

Are you currently working? (Mark one)

_____ Full-time
_____ Part-time
_____ Not working due to pain
_____ Not working due to non-pain reasons
_____ Homemaker

If married, is your spouse?

_____ Working?
_____ Not working, on disability?
_____ Not working, not on disability?
_____ Homemaker?

If you are not working, how long has it been since you worked? _____years, _____months

Out of the past year, how many weeks have you worked? _____weeks

What is your present (or last) job?_____

List duties:_____

_____

_____

How many months did you work for your last employer before being injured? _____months

Did you have a union dispatch job? _____yes _____no

What is the number of jobs you have held in the last 5 year? _____

List previous jobs: _____

_____

_____

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New Patient Questionnaire

Insurance Information

Did your present pain begin with a work injury? _____yes _____no

From which of the following sources do you receive income?

_____ Wages, earned income

_____ Injury or sickness compensation (e.g. L&I), private disability insurance

_____ Unemployment benefits

_____ Retirement (because of age), pension, social security

_____ Retirement, medical retirement, or social security disability

_____ Other disability insurance (e.g. mortgage)

_____ Other, please specify: _____

What is your monthly take home income at this time? _____

What is your total family take home income at this time? _____

How much of this disability/time loss payment?_____

What was your monthly take home income at the time of your injury?_____

Have you hired any attorney to help you with a worker's compensation claim? _____yes _____no

Have you hired any attorney to help you with a lawsuit regarding your injury? _____yes _____no