MedStar National Rehabilitation Network

Patient Name: ______________________________

Date of Birth: ______________________________

Outpatient Health History (Confidential)

Primary Care Physician: ________________________ **Ref Provider:** ________________________
Reason for visit: ____
Person completing form: ______________________ ☐ **Patient** ☐ **Other**________**Date:** ________

PHARMACY

1. Name of Pharmacy:
   ____
2. Address of Pharmacy:
   ____
3. Phone number of Pharmacy?
   ____
4. Mail Order? ☐ Yes ☐ No

ALLERGIES/ DRUG INTERACTIONS

Please list:

____

*** Many rehab clinic products contain Latex. Do you have any allergy to Latex?** ☐ Yes ☐ No

CURRENT MEDICATIONS (INCLUDE OVER-THE-COUNTER MEDICATIONS AND HERBAL PREPARATIONS)			
Medication Name	**Dose**	**Frequency**	**Reason**

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DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? (ROS-CS)

	YES	NO		YES	NO
Cough productive sputum	☐	☐	Bladder problems	☐	☐
Fever	☐	☐	Painful urination	☐	☐
Chills	☐	☐	Incontinence of urine	☐	☐
Coughing up blood	☐	☐	Incontinence of stool	☐	☐
Night sweats	☐	☐	Frequent falls	☐	☐
Nausea	☐	☐	Seizures	☐	☐
Vomiting	☐	☐	Depression	☐	☐
Chest pain	☐	☐	Loss of sleep	☐	☐
Difficulty breathing	☐	☐	Loss of appetite	☐	☐
Joint pain	☐	☐	Infrequent bowel movements	☐	☐
Joint stiffness	☐	☐	Sexual dysfunction	☐	☐
Rash	☐	☐	Vertigo	☐	☐
Changes in color of skin	☐	☐	Irritability	☐	☐
Visual changes	☐	☐	Headaches	☐	☐
Hearing problems	☐	☐	Memory problems	☐	☐
Constipation	☐	☐	Confusion/altered mental status	☐	☐
Bloody stools	☐	☐	Difficulty with concentration	☐	☐

NUTRITION:

1. Are you concerned about your nutrition? ☐ Yes ☐ No
2. Have you had an unexplained weight loss? ☐ Yes ☐ No
3. Have you had an unexplained weight gain? ☐ Yes ☐ No Specify loss or gain: _____
4. Current weight:___________
5. Current height: ___________

FALLS:

1. Have you fallen in the last 30 Days? ☐ Yes ☐ No When: ____
2. Has any falls resulted in injury? ☐ Yes ☐ No Specify:____

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PAIN:

Do you currently have pain or have you had pain in the recent past?

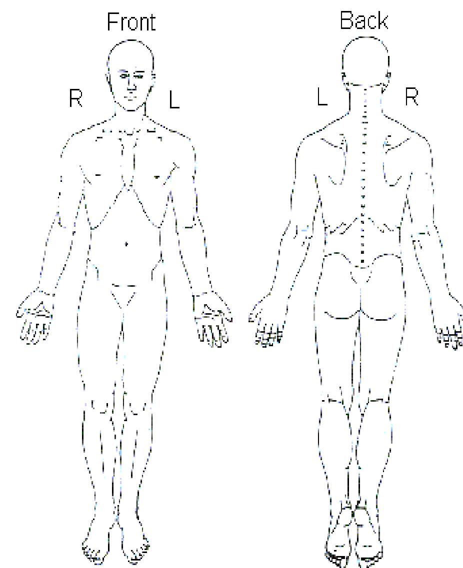
- ☐ **Yes**, if yes complete pain questionnaire below
- ☐ **No**

Quality: How would you describe your pain?

☐ Aching	☐ Radiating
☐ Burning	☐ Sharp
☐ Cramping	☐ Throbbing
☐ Dull	☐ Tightness
☐ Heavy	☐ Unable to describe
☐ Pressure	☐ Other:

On the diagram below, shade in the **body part** where you feel pain.

Put an X on the area that hurts most:



1. Please rate your pain by circling the number that describes your pain at **its worst in the last three (3) days:**

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain

2. Please rate your pain circling the number that describes your pain at **its least in the last three (3) days:**

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain

3. Please rate your pain by circling the number that tells how much **pain you have right now:**

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain

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Aggravating Factors: PLACE A (✓) BESIDE WHAT **MAKES YOUR PAIN WORSE**

Nothing	Bending	Certain movement	Walking up stairs	Heat
Activity	Bending forward	Change in positions	Walking down stairs	Stretching
Sitting	Bending backwards	Reaching up	Lying down	Weather changes
Standing	Twisting	End of day	Lying on side	Rainy weather
Walking	Turning	Morning activities	Squatting	Cold weather
Lifting	Driving	Evening activities	Kneeling	Hot weather
Carrying	Sneezing	Sitting up for long	Ice	Yoga

Alleviating Factors: PLACE A (✓) BESIDE WHAT **RELIEVES YOUR PAIN**

Nothing	Standing	Driving	Walking down stairs	Heat
Rest	Walking	Certain movement	Lying down	Stretching
Medications	Bending	Change in positions	Sleeping	Weather changes
Activity	Bending forward	Morning activities	Lying on side	Rainy weather
Exercise	Bending backwards	Evening activities	Squatting	Cold weather
Massage	Twisting	Sitting for long periods	Kneeling	Hot weather
Sitting	Turning	Walking up stairs	Ice	Yoga

WHAT PRIOR TREATMENT HAVE YOU TRIED FOR YOUR PAIN? PLACE A (✓)

No treatment	Physiatrist
Medications	Orthopedist
Physical therapy	Pain management
Occupational therapy	Opiod pain management
Emergency department	Neurosurgeon
Occupational health	Chiropractor
Primary care physician	

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Chronic Low Back Pain Questionnaire (Confidential)

Do you currently have back pain or have you had back pain in the recent past?

- ☐ **Yes, if yes complete back pain questionnaire below**
- ☐ **No, please do not complete the questionnaire below**

Modified Oswestry Disability Index (ODI)

Instructions: Please enter a number in each box that best describes your back pain.

Pain Intensity ☐

1 = I can tolerate the pain I have without having to use pain medication
2 = The pain is bad, but I can manage without having to take pain medication
3 = Pain medication provides me with complete relief from pain
4 = Pain medication provides me with moderate relief from pain
5 = Pain medication provides me with little relief from pain
6 = Pain medication has no effect on my pain

Personal Care
(washing, dressing, etc.) ☐

1 = I can look after myself without causing extra pain
2 = I can look after myself normally but it causes extra pain
3 = It is painful to look after myself and I am slow and careful
4 = I need some help but manage most of my personal care
5 = I need help every day in most aspects of self-care
6 = I do not get dressed, I wash with difficulty, and I stay in bed

Lifting ☐

1 = I can lift weights without extra pain
2 = I can lift heavy weights but it gives extra pain
3 = Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
4 = Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
5 = I can lift very light weights

Walking ☐

1 = Pain does not prevent me walking any distance
2 = Pain prevents me from walking more than 1 mile
3 = Pain prevents me from walking more than ½ mile
4 = Pain prevents me from walking more than ¼ mile
5 = I can only walk with crutches or a cane
6 = I am in bed most of the time and have to crawl to the toilet

Sitting ☐

1 = I can sit in any chair as long as I like
2 = I can only sit in my favorite chair as long as I like
3 = Pain prevents me from sitting more than one hour
4 = Pain prevents me from sitting more than 30 minutes
5 = Pain prevents me from sitting more than 10 minutes
6 = Pain prevents me from sitting almost all the time

Standding

☐

1 = I can stand as long as I want without extra pain
2 = I can stand as long as I want but it gives me extra pain
3 = Pain prevents me from standing more than one hour
4 = Pain prevents me from standing more than 30 minutes
5 = Pain prevents me from standing more than 10 minutes
6 = Pain prevents me from standing at all

Sleeping

☐

1 = Pain does not prevent me from sleeping well
2 = I can sleep well only by using tablets
3 = Even when I take tablets I have less than 6 hours sleep
4 = Even when I take tablets I have less than 4 hours sleep
5 = Even when I take tablets I have less than 2 hours sleep
6 = Pain prevents me from sleeping at all

Social Life

☐

1 = My social lift is normal and gives me no extra pain
2 = My social life is normal but increases the degree of pain
3 = Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing
4 = Pain has restricted my social life and I do not go out as often
5 = Pain has restricted my social life to my home
6 = I have no social life because of pain

Traveling

☐

1 = I can travel anywhere without pain
2 = I can travel anywhere but it gives me extra pain
3 = Pain is bad but I manage journeys over two hours
4 = Pain restricts me to journeys of less than one hour
5 = Pain restricts me to short necessary journeys under 30 minutes
6 = Pain prevents me from traveling except to receive treatment

Employment Homemaking

☐

1 = My normal homemaking/job activities do not cause pain
2 = My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
3 = I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
4 = Pain prevents me from doing anything but light duties
5 = Pain prevents me from doing even light duties
6 = Pain prevents me from performing any job or homemaking chores

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Staff Only: Check box to signify completion into EHR ☐