AdventHealth
Shawnee Mission

Patient Assessment Form

(Please fill out this form and bring it with you to your appointment.)

Name_____ Date of Birth: _____ Todays Date: _____

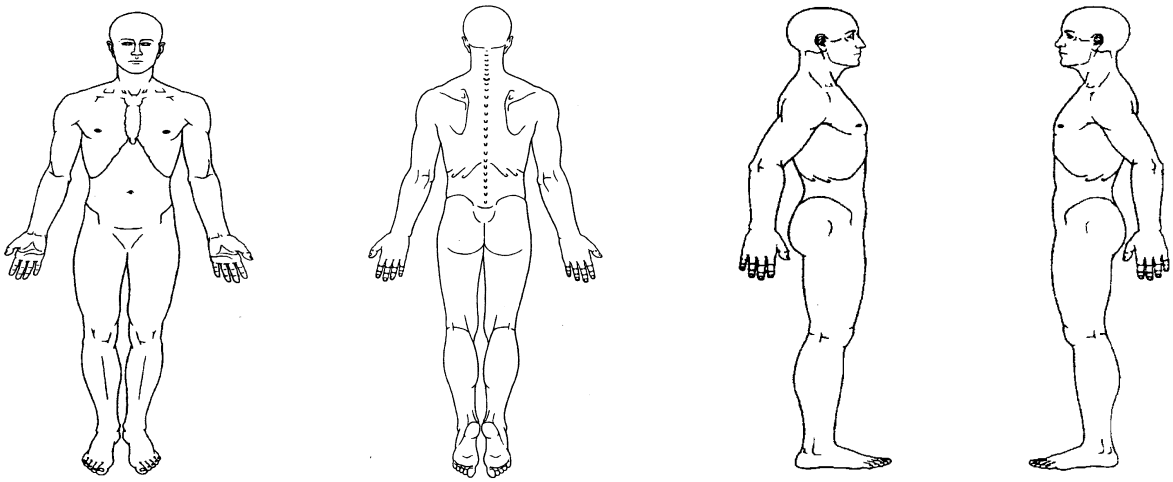
Age_____ Sex: M _____ F _____ Height: _____ft. _____ in. Weight _____ lbs.

Primary Physician _____

Referring Physician (If Different): _____

CURRENT PROBLEM

Please draw where your primary pain is located using the diagrams below:



When did the pain begin? _____

Did it begin gradually or suddenly? _____**If suddenly, is it the result of an injury?** _____**Yes** _____**No**

If result of an injury, describe the injury_____

If not a result of injury, what do you think caused your pain? _____

_____

Since your pain started is it (circle one) ☐ **Worse** ☐ **Unchanged** ☐ **Intermittent** ☐ **Better** ☐ **N/A**

Please describe your pain in as much detail as possible _____

_____

_____

Do you have any other symptoms such as numbness, weakness, or pins and needles sensation? Please describe.

_____

HISTPHY

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Oswestry Disability Index

Instructions: this questionnaire has been designed to give us information as to how your pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the **one** box which most closely describes your current condition.

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 (washing, dressing, etc.)
- ☐ I can look after myself normally without pain.
- ☐ I can look after myself normally, but it is very painful.
- ☐ 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.

Section 3 — Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e., 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.

Section 4 — Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than I mile.
- ☐ Pain prevents me from walking more than 1/2 of a mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using an assisted device, i.e., a walker.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 — Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ an hour.
- ☐ Pain prevents me from sitting for 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 more than 1 hour.
- ☐ Pain prevents me from standing for more than 1/2 an hour.
- ☐ 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 of 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 causes 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, i.e., sports.
- ☐ 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 extra pain.
- ☐ Pain is bad, but I manage journeys of over two hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

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HISTORY OF TREATMENTS

Please indicate whether or not you have had any of these tests for your present problem:

	YES	NO	WHEN	WHERE
REGULAR X-RAYS	☐	☐		
CT SCAN	☐	☐		
MYLEOGRAM	☐	☐		
MRI	☐	☐		
BONE SCAN	☐	☐		
BLOOD TESTS	☐	☐		
EMG (nerve test)	☐	☐		
DISCOGRAM	☐	☐		

Please indicate the following treatments you have tried in the past.

TREATMENTS	DATE	BETTER		OUTCOME	NA
		yes	no		
Exercise					
Physical Therapy					
Occupational Therapy					
Chiropractic					
Counseling					
Biofeedback					
Injections/Nerve Block					
TENS Unit					
Medications					

HISTORY OF PAST PROVIDERS

Please list the names of all physicians, chiropractors, psychiatrist, psychologist, osteopaths, or other pain facilities whom you have seen for your present problem. List them in the order in which you saw them from first to last.

NAME OF PHYSICIAN	SPECIALTY	DATE FIRST SEEN	DATE LAST SEEN

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PAST MEDICAL HISTORY

Do you have, or have you had any of the following conditions? (Please Check All That Apply)

ENDOCRINE
- ☐ Diabetes
- ☐ Hypo/Hyperthyroid

HEMATOLOGY
- ☐ Bleeding disorder
- ☐ Anemia

RHEUMATOLOGY
- ☐ Arthritis, Type_____
- ☐ Fibromyalgia

CARDIAC
- ☐ Heart Attack
- ☐ Congestive Heart failure
- ☐ Coronary Artery Disease
- ☐ Valvular heart Disease
- ☐ High Blood Pressure

GENITOURINARY
- ☐ Incontinence
- ☐ Bladder control problems
- ☐ Kidney disease
- ☐ Kidney infections

GASTROINTESTINAL
- ☐ Ulcers
- ☐ Gallstones
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Pancreatitis
- ☐ GERD/reflux disease

OTHER

Cancer, Type _____
_____
_____
_____
_____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD

NEUROLOGICAL
- ☐ Stroke/TIA
- ☐ Migraines

PSYCHIATRIC
- ☐ Bipolar disease
- ☐ Depression
- ☐ History of Drug/Alcohol problems
- ☐ Other mental illness_____
- ☐ Anxiety

Please provide any additional about the above conditions below, or list other conditions not covered on the above list:

_____

_____

_____

PAST SURGICAL HISTORY

Please list any surgeries you have had including procedure and date:

Surgery	Year	Facility/Physician

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CURRENT MEDICATIONS

***ARE YOU TAKING ANY BLOOD-THINNING MEDICATIONS*? (e.g. ASPIRIN, COUMADIN, HEPARIN, TICLID, PLAVIX (CLOPEDIGREL) PLETAL, LOVENOX, ARISTA, JANTOVEN, WARFARIN, OTHER _____ YES☐ NO☐**

Please list any medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers.

Medication & Dose	How often	Medication & Dose	How often
1)		10)	
2)		11)	
3)		12)	
4)		13)	
5)		14)	
6)		15)	
7)		16)	
8)		17)	
9)		18)	

DRUG ALLERGIES

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO If yes, please list the medication and the reaction:

This includes: medications, food, latex, iodine, environmental agents or irritants

Item/Drug	Reaction	Item/Drug	Reaction

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REVIEW OF SYSTEMS

Do you have any of the following symptoms? Please circle all that apply.

- ***GENERAL***: Weight loss, rashes, itching, color changes, headaches, dizziness, fever or chills, night sweats
- ***EYES***: Blurred vision, light sensitivity, deficits in your vision, changes in your vision.
- ***EAR,NOSE,THROAT***: Sinus problems, trouble swallowing, ringing in your ears, dental problems.
- ***CARDIAC***: Chest pain, palpitations, poor circulations, swelling in extremities, poor exercise tolerance
- ***REPIRATORY***: Shortness of breath, difficulty breathing, wheezing, coughing, sputum production.
- ***URINARY***: Painful urination, difficulty urinating, bladder control problems, frequent urinary infections.
- ***GASTROINTESTINAL***: Heartburn, nausea, vomiting, diarrhea, bloody stools, constipation.
- ***MUSCULOSKELETAL***: Achy swollen joints, stiff joints, muscle spasms, sore/ tender muscles.
- ***SKIN***: Rashes, skin irritations, skin ulcers.
- ***NEUROLOGICAL***: Poor memory, headaches, poor balance, loss of consciousness, fainting, muscle weakness, numbness, or changes in sensation.
- ***PSYCHOLOGICAL***: Anxiety, depression, increased emotional stress, hallucinations, paranoia, suicidal ideations (thoughts of harming yourself difficultly with concentration.
- ***ENDOCRINE***: Always thirsty, always hot, always cold, hair and nail changes.
- ***HEMATOLOGY***: Easy bruising, cuts take a long time to stop bleeding, painful lymph nodes, frequent leg swelling, fatigue.
- ***ALLERGIC/IMMUNE***: are you prone to infections, sensitive to many foods, medicines

FAMILY HISTORY

Please list any significant medical problems for any blood relatives(parents, grandparents, brothers or sisters) also list any medical problems that tends to run in your family.

_____

_____

_____

SOCIAL HISTORY

Marital Status: Single☐ Married☐ Divorced☐ Widowed☐

Indicate current household members: Self☐ Spouse☐ Children☐ Other☐

_____

What kind of support do you have to help you cope with this problem? (e.g. family, friends, church, etc.)

_____

EXERCISE: Type of exercise:_____

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Days/Week:_____

TOBACCO USE: Do you currently use tobacco products? ☐ Yes ☐ NO

IF YES, how many packs a day? _____ How many years?_____

IF FORMER SMOKER, when did you quit? _____ before you quit, how many packs a day _____ and how many years_____

Do you drink caffeinated beverages? ☐ YES ☐ NO If yes, how many cups/cans per day? _____

Do you drink alcoholic beverages? ☐ YES ☐ NO If yes, how many beverages per week? _____

Have you ever had, or do you have a substance abuse problem? Yes☐ No☐

Are you currently employed? ☐ Yes ☐ No. If yes, please complete the following questions:

Your current employer _____

Your current occupation _____

Your usual duties include: _____

Are you involved with Workman's compensation? ☐ Yes ☐ No

If so, what is the name and phone number of your case worker? _____

OTHER

Is there any chance you could be pregnant? ☐ YES ☐ NO If yes, when is your due date?

Primary Language: ☐ English ☐ Spanish ☐ Other_____ Do you need an interpreter? ☐ YES ☐ NO

Are you hard of hearing? ☐ YES ☐ NO Do you need glasses to read? ☐ YES ☐ NO

Would you like to have a consult with a dietician to discuss any dietary concerns? ☐ YES ☐ NO

Are there any religious or cultural factors which may impact your care while in the clinic? ☐ YES ☐ NO

If yes, please explain_____

Do you, or anyone you know, need information regarding problems of abuse and/or neglect? Yes ☐ No ☐

What are your realistic goals for treatment of your pain? (check all that apply)

To be pain free ☐ Help living with pain ☐ Other _____

Reduced pain ☐ Increased activity ☐

Thank you for your time in completing this form

Patient signature: Date:

_____ _____