Medical Rehabilitation Group, P.C.
4632 Genesys Parkway
Grand Blanc, MI 48439
Ph. 810-606-7181

Your appointment is with:
Dr.: _____
Date: _____
Time: _____

New Patient Questionnaire

Dear Patient:

So that we may better serve your needs, **PLEASE COMPLETE THIS QUESTIONNAIRE AND BRING WITH YOU TO YOUR APPOINTMENT.** Be sure to call us as soon as possible if you cannot make your appointment. Thank you.

Name _____
Date of Birth_____ Age_____
Address_____
City_____State_____Zip_____
Phone #_____ Cell: _____
Referring physician_____

Questions About Your Current Problem

1. When did your pain problem first occur?_____

2. When did this episode of pain begin? _____

3. How did it happen? Accident at work Accident at home After surgery
Car accident Other accident_____
Following illness No specific cause

4. Have you ever had this pain before? If yes, explain. _____
_____

5. Place an X on each line between 0 and 10 to indicate your level of pain in the last week:
Worst this week_____
No pain 0 10 worst possible pain
Best this week_____
No pain 0 10 worst possible pain
Average week _____
No pain 0 10 worst possible pain

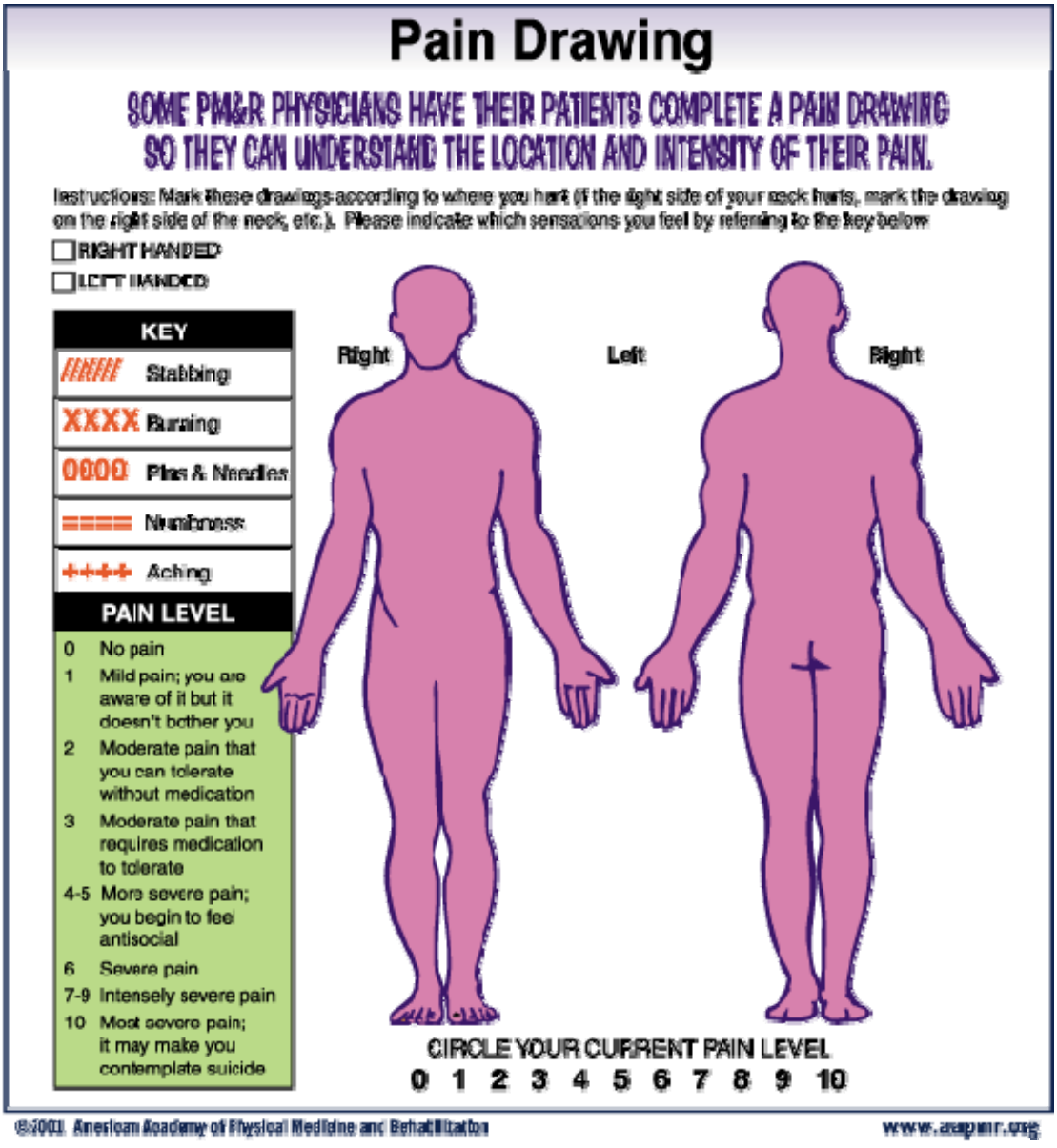
6. What makes your pain worse?_____

7. What makes your pain better?_____

8. What do you think is the cause of your pain?_____

9. Where is your pain located?

Mark the area on the body where you feel the described sensations using the following:



Treatment History

Please check all treatments you have received for this problem:

Medication	Physical therapy	Surgery
Injections	Chiropractic	TENS
Occupational therapy	Psychological	Acupuncture
Biofeedback	Pain program	Massage

Homeopathic or other alternative medicine (list):_____

Diagnostic Tests

Please check which tests have been done for this problem:

Test	What body part	When done	Where
X-ray	_____	_____	_____
MRI	_____	_____	_____
CT (CAT scan)	_____	_____	_____
Bone scan	_____	_____	_____
EMG	_____	_____	_____

Medications

Please list **all** medications you are currently taking for any reason (include non-prescription drugs). Attach list if necessary.

Drug name	Dose	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy: _____ **Phone #:** _____

Please list all known drug allergies: _____

Family History

Has any family member had any of the following? Please check all that apply.

Yes	No	Any blood relatives who have had a heart attack before age 55?
Yes	No	Disabling back pain
Yes	No	Herniated disc
Yes	No	Rheumatoid arthritis
Yes	No	Lupus
Yes	No	Nerve or muscle disease (specify)_____
Yes	No	Disability from work for other reasons

Functional History Please check all that apply:

Yes No Do you have trouble sleeping due to your pain?
Number of hours of sleep/night_____
Yes No Difficulty with prolonged sitting?
Yes No Difficulty with prolonged walking?
I can walk_____min before needing to sit or rest due to pain
Yes No Difficulty with prolonged standing?
Yes No Avoid certain activities due to pain?

Social History

Please check each that apply:

Marital status: Single Married Divorced Widowed

Who do you live with? Alone Children (ages)_____
Spouse Parents
Significant other Friends or relatives

How much alcohol do you usually drink? None
1-5 drinks per week
6-12 drinks per week
More than 12 drinks per week

Yes No Have you been treated for drug or alcohol abuse?
Yes No Do use street drugs?
Yes No Do you smoke cigarettes? If yes, how many packs/day?_____

Number of years of schooling completed_____ eg 11th grade, college, etc.

Aside from your current problem, what are the most stressful things in your life?_____
_____

Work History

Occupation_____
Employer_____

Yes No Are you currently off work because of this problem? How long?_____
Yes No Do you believe this problem is caused by your work?
Yes No Are you working with restrictions? If yes, please list_____
_____

Yes No Are you currently receiving any compensation for your pain problem?
If yes, please check all sources that apply:

Workers comp
Social security disability
Supplemental security income
Short term medical disability
No-fault auto insurance
Long term medical disability
Sick leave disability benefits

Yes No Have you consulted with an attorney for any matters related to this problem?

Yes No Are you currently involved in any legal action related to your pain?
If yes, please check all that apply:
Suit for No fault auto insurance
Suit for social security disability income
Suit against a third party (employer, driver of another vehicle, doctor.)
Suit to increase your current compensation benefits

Health History

Please check all that apply:

Yes No History of tumors or cancer If yes, what type?_____
Yes No History of diabetes. If yes, do you use insulin? Yes / No
Yes No History of stroke
Yes No History of high blood pressure
Yes No History of heart disease
Yes No History of respiratory problems (eg emphysema, asthma)
Yes No History of head injury with loss of consciousness
Yes No History of epilepsy (seizures)
Yes No History of rheumatoid arthritis or lupus
Yes No History of nerve or muscle disease If yes, specify:_____
Yes No History of depression
Yes No History of thyroid disease
Yes No History of gastrointestinal reflux (GERD)
Yes No History of HIV, AIDS

System Review

Are you currently experiencing any of the following? Please check all that apply:

Yes No Fever
Yes No Weight loss without dieting. If yes, how much:_____
Yes No Weight gain. If yes, how much:_____
Yes No Loss of bladder control
Yes No Loss of bowel control
Yes No (Men) Difficulty with erections
Yes No Blood in your urine
Yes No Blood in your bowel movements
Yes No Chest pain when you work hard
Yes No Shortness of breath
Yes No Frequent headaches
Yes No Double or blurry vision
Yes No Slurring of speech
Yes No Difficulty chewing or swallowing
Yes No Jaw pain
Yes No Skin rash

Yes	No	Joint pains
Yes	No	Heartburn
Yes	No	Anxiety or panic attacks
Yes	No	Feeling sad most of the time
Yes	No	Thoughts of suicide
Yes	No	Loss of interest in things you used to enjoy doing
Yes	No	Get tired easily
Yes	No	Flashbacks or nightmares of accident or incident that caused the pain
Yes	No	Involved in an abusive relationship