REHABILITATION MEDICINE ASSOCIATES
OF EUGENE-SPRINGFIELD P.C.

242 Country Club Road
Eugene OR 97401-2477
PH: (541) 683-4242
FAX: (541) 343-5078
www.rmaeug.com

NEW PATIENT QUESTIONNAIRE

PART 1

Name ______________________________ Date of birth __________ Today's date ____________

Primary care provider ____________________________ Check one: ☐ Right-handed ☐ Left-handed

Reason for today's visit____

What are your goals in seeking help with this problem? _______________________________

Date problem began ______________________ Onset was (check one) ☐ Sudden ☐ Gradual

Is problem the result of accident or injury? ☐ YES ☐ NO

If yes, check applicable ☐MVA ☐Job injury ☐ Other: ________________________

If this is the result of an injury did you have similar symptoms at any time before the injury?____

If your visit does <u>not</u> address a painful condition, skip to PART 2 on page 3

On the diagrams, mark the areas on your body where you feel the described sensations with the symbols on the left

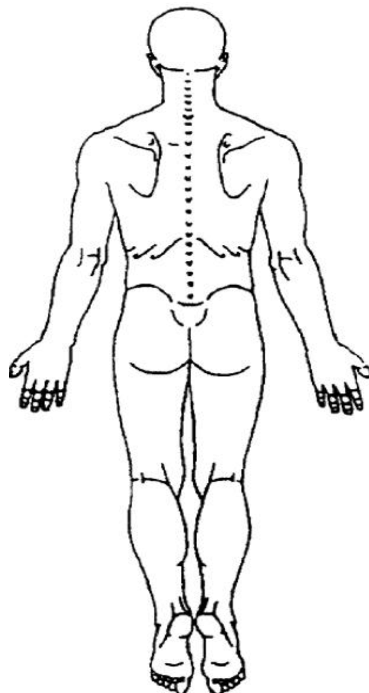
-----
----- Numbness

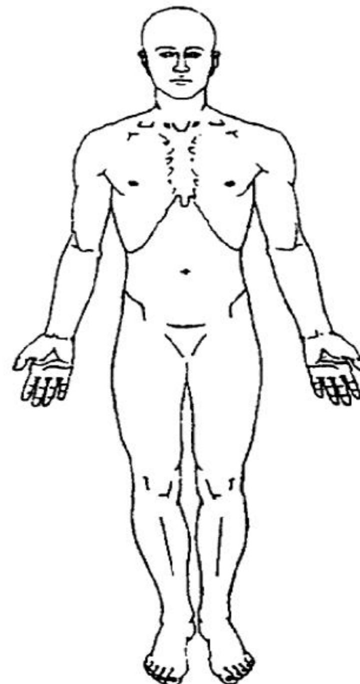
○○○
○○○ Pins&needles

xxx
xxx Burning

///
/// Stabbing

●●●
●●● Aching





Left **Right** **Right** **Left**

PART 1 - Continued

Rate your pain on the scale with an **X.** 0= no pain 10=worst possible pain

Average Pain Recently

0---10

Least pain in last 2 weeks

0---10

Worst pain in last 2 weeks

0---10

Is your pain (circle one):

always present

comes and goes

Do you have loss of strength? YES NO If YES, where? ______________________________

Do you have loss of feeling or touch? YES NO If YES, where? ______________________________

Do you lose control of your bladder? YES NO

Do you lose control of your bowels? YES NO

How do these activities affect your pain?

	Decrease	**Increase**	**No Effect**
Turning your head	□	□	□
Lifting arms	□	□	□
Sitting	□	□	□
Walking	□	□	□
Lying Down	□	□	□
Work	□	□	□
Bending forward	□	□	□

What activities does the pain keep you from doing?____________________________________

Please list all x-rays, MRI's, bone scans, EMG/nerve conduction studies, blood tests, related to current problem:

Name of test	Date	Place

Please list any pain medications you have **tried** in the past but are **not** currently taking.

Medication	Strength (mg)	How many tablets at one time?	How many times a day?	How long did you take this?	On scale of 0-10, how much relief did this provide?	Why did you stop taking this?

What other treatments have you tried?

□ Physical therapy
□ Chiropractic treatment
□ Acupuncture
□ Massage therapy
□ Surgery
□ Spinal injections
□ Trigger point injections
□ Other ________________________

PART 2 - Review of Systems

During the past year, have you had any of the following symptoms?

Symptoms: **Explanation:**

◻ Persistent fevers ______________________________
◻ Night sweats ______________________________
◻ Unintentional weight loss ______________________________
◻ Joint aching, stiffness or pain ______________________________
◻ Rash ______________________________
◻ Sleep difficulty ______________________________
◻ Fatigue ______________________________
◻ Dizziness or vertigo ______________________________
◻ Depression ______________________________
◻ Vision changes ______________________________
◻ Easy bruising ______________________________
◻ Excessive bleeding ______________________________
◻ Persistent diarrhea ______________________________
◻ Constipation ______________________________
◻ Dark or bloody stools ______________________________
◻ Urinary incontinence ______________________________
◻ Blood in the urine ______________________________
◻ Trouble breathing ______________________________
◻ Memory problems ______________________________
◻ Frequent falls ______________________________
◻ Seizures ______________________________
◻ Headaches ______________________________

PART 3 – Past Medical History

Please (√) all the conditions which you either currently have or have had:

◻ Heart attack/angina ◻ High blood pressure ◻ Stroke ◻ Diabetes
◻ Ulcers ◻ Thyroid disease ◻ Kidney disease ◻ Liver disease
◻ Arthritis ◻ Cancer (type :_____________) ◻ Fibromyalgia
◻ Depression ◻ PTSD ◻ Physical/psychological/sexual abuse
◻ Anxiety ◻ Bipolar disorder
◻ Other condition(s) ______________________________

LIST ALL SURGERIES AND DATES

Type of Surgery	Date	Type of Surgery	Date
1.		4.	
2.		5.	
3.		6.	

LIST ALL MEDICATIONS YOU TAKE (including non-prescription)

Medication	Strength (mg)	How many tablets at one time?	How many times a day?	On scale of 0-10, how much relief does this provide?

Preferred Pharmacy: ____

Allergies: Please check (√) any medication to which you have had an allergic reaction (hives/rash/wheezing, etc.)

□penicillin □sulfa □aspirin/ibuprofen/NSAID's □iodine dye □iodine on the skin
□tetanus-antitoxin □latex □codeine □morphine □local anesthetics □tape
□other: ____

PART 4 – Social History

Habits: Please check (√) all that apply

Do you have an exercise program? □No □Yes ___________________________
Do you smoke or use tobacco? □No □Yes – How many packs per day? ________
Do you drink caffeinated beverages (Coffee, tea, cola)? # Per day ________
Do you drink alcohol? □No □Yes - Age started ____ # drinks per week____
Have you tried alcohol to help your pain? □No □Yes
Do you use cannabis products? □No □Yes □edible □inhaled □topical
Have you ever used illegal/street drugs in the past? □No □Yes
Do you now? □No □Yes
Did you ever have a problem with drinking excessive amounts of alcohol? □No □Yes
If yes, did you quit drinking? □No □Yes If yes, when? _______________
Have you ever abused or been addicted to pain pills? □No □Yes

Marital Status?

□ Single □ Married □ Domestic partner □ Divorced □ Separated □ Widow/Widower
Do you have children at home? □No □Yes
If you have children at home list their ages: _________________________________

Education: (Check the highest level you completed)

□Grade school □High school □GED □Trade school □College degree □Graduate degree

PART 5- Work History

Are you: **<u>If disabled, why?</u>**

□Currently working □Permanently disabled ______________________________

□Retired ______________ □Temporarily disabled ______________________________

Have you applied for disability benefits? □Yes □No

Current/Recent employer: ____________________________ Length of time with employer _______

Last day worked _________________________ Usual occupation ______________________________

Physical demands of your job:

□Very Heavy (lift >100 lbs) □Heavy (lift >50 lbs) □Moderate (lift >35 lbs)

□Light (lift 15-25 lbs) □Repetitive hand tasks □Sedentary (No lifting)

PART 6 – Family History

	Living?	State of health	Age/Cause of death
Mother	□Yes □No	□Good □Fair □Poor	________________________________
Father	□Yes □No	□Good □Fair □Poor	________________________________

Family history of disease? (List): ____

____

Is anyone in your family on disability? (List): ____

____

Does anyone in your family abuse drugs or alcohol? (List): ____

____