SIMED
SOUTHEASTERN INTEGRATED MEDICAL

Southeastern Rehabilitation Medicine

Initial (New) Outpatient Information Questionnaire

Name: _____ MR#:_____ Date: _____

Date of Injury: _____ Referred By: _____

Age: _____ Date of Birth: _____ Handed: □ R □ L □ Ambidextrous □ Male □ Female

****** Mark appropriate squares □: (Made add comments in open lines) If you mark "YES" explain on line ******

Main Reason (Complaint) for Today's Visit: (In your own words) _____

_____

Briefly Describe Accident or Development of Present Complaint: _____

_____

_____

_____

Are Symptoms Related to an Accident or Trauma?: □ N/A □ Yes □ No Date: _____

If related to motor vehicle accident:

Were you the driver? □ Yes □ No Were you wearing a seat belt? □ Yes □ No

Were you □ Stopped □ Moving At what speed were you travelling? _____

Were you hit □ Head On □ Driver's Side □ Passenger's Side □ Rear of Vehicle At speed _____MPH

Did you have loss of consciousness? □ Yes □ No If yes, for how long? _____

Was airbag deployed? □ Yes □ No Did you go to the emergency room? □ Yes □ No Hospital: _____

Complaint's Characteristics:

When did symptoms start? (Date) _____ How did symptoms start? □ Gradual □ Sudden

Are symptoms □ Continuous □ Intermittent (Off and On)

Are symptoms □ Mild □ Moderate □ Severe Pain Scale (0-10): _____

Pain characteristic: □ Dull □ Sharp □ Burning □ Tooth-ache like □ Stabbing

□ Pressure Like □ Throbbing □ Other: _____

Does *pain refer* to other areas? □ Yes □ No Where? _____

What makes the symptoms worse? □ N/A □ Sitting □ Standing □ Walking □ Lying Down

□ Lifting □ Bending □ Twisting □ Coughing □ Driving

What makes the symptoms better? _____

Associated Symptoms:

Do you have *Numbness*? □ Yes □ No Where? _____

Do you have *Tingling*? □ Yes □ No Where? _____

Do you have *Weakness*? □ Yes □ No Where? _____

Do you have symptoms at *Night*? □ Yes □ No Where? _____

Do you have problems *Urinating*? □ Yes □ No Explain _____

Do you have *Bowel Function* problems? □ Yes □ No Explain _____

Do you have *Sexual Dysfunction*? □ Yes □ No Explain _____

Are symptoms: □ Increasing □ Decreasing □ Remain about the same

What treatments have you tried? □ Medications □ Physical Therapy □ Chiropractic Care

□ Surgery □ Injections □ Electrical Stimulation □ Braces/Cane □ Acupuncture

□ Other: _____

By whom (or where) have you been treated for this problem? _____

Primary Care Physician: _____ Attorney: _____

Pharmacies used in the last two years (name and city): _____

What tests have you had for this problem? □ Myelogram □ MRI □ CAT Scan

□ Electrodiagnostic Studies □ Bone Scan □ Arthrogram □ X-Ray □ Other: _____

Your Past Medical History: Mark appropriate squares □ : (May add comments in open lines)

Diabetes	□ Yes	□ No	On Blood Thinner	□ Yes	□ No
Thyroid Disease	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Arthritis	□ Yes	□ No	HIV / AIDS	□ Yes	□ No
Heart Disease	□ Yes	□ No	Stroke	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Polio	□ Yes	□ No
Pace Maker	□ Yes	□ No	Lung Disease	□ Yes	□ No
Vascular Disease	□ Yes	□ No	Sleep Apnea	□ Yes	□ No
Cancer	□ Yes	□ No	Depression / Bipolar	□ Yes	□ No
Ulcers	□ Yes	□ No	Schizophrenia	□ Yes	□ No
Liver Disease	□ Yes	□ No	Prior Suicide Attempt	□ Yes	□ No
Glaucoma	□ Yes	□ No	Seizures	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Gastric band/bypass	□ Yes	□ No

□ Other: _____

Do you have a history of substance abuse? □ Yes □ No □ N/A □ Quit When? _____

If history of substance abuse, please explain: When? What substance(s)? For how long? Any Treatments?

_____

Have you ever been denied care or released by any healthcare providers because of violations to their drug policies? □ Yes □ No Where & When? _____

Any history of arrests or convictions due to illegal substances or alcohol issues? □ Yes □ No

Habits: Do you smoke? □ Yes □ No □ Quit How much? _____

Do you drink alcohol? □ Yes □ No □ Quit How much? _____

List surgeries or operations: _____

_____

List other injuries or accidents in past: _____

List current medications: (Including over the counter medications): _____

_____

List medications tried in the past for this problem: _____

_____

List medication allergies: □ None _____

*List any medical problems **in your family:*** _____

Check your current status: □ Married □ Single □ Divorced □ Separated □ Widow

Hobbies: _____

Your work history: Occupation: _____ Education level / Training: _____

Describe your job: _____

Place of work: _____ Are you still working? □ Yes □ No

Last Worked: (Date) _____ How many hours per week? _____ Any Restrictions? □ Yes □ No

Do you receive? Disability Check □ Yes □ No Worker's Comp Check □ Yes □ No

ROS: Check "□" for active symptoms or "O" for prior inactive symptoms. Leave blank absent symptoms.

*Fever	□ / O	*Short of Breath	□ / O	*Weakness	□ / O	*Depression	□ / O
Chills	□ / O	Cough	□ / O	Joint Pain	□ / O	Anxiety	□ / O
Weight Loss	□ / O	Sputum	□ / O	Joint Swelling	□ / O	Irritable	□ / O
*Blurred Vision	□ / O	*Nausea	□ / O	Pain in Back	□ / O	Decreased Sleep	□ / O
*Headache	□ / O	Vomiting	□ / O	Joint Stiffness	□ / O	*Night Sweats	□ / O
Hearing Loss	□ / O	Blood in Stool	□ / O	Muscle Cramps	□ / O	Heat Intolerance	□ / O
Hard to Swallow	□ / O	Diarrhea	□ / O	*Rashes	□ / O	Cold Intolerance	□ / O
Nasal Stuffiness	□ / O	Stomach Pain	□ / O	Nipple Discharge	□ / O	*Bruise Easily	□ / O
*Chest Pain	□ / O	*Pain when urinating	□ / O	*Seizures	□ / O	Allergies	□ / O
Palpitations	□ / O	Discharge from genitals	□ / O	Memory Loss	□ / O	*Current Infection	□ / O
*Recent Fractures	□ / O	*Other: _____					

Are you pregnant? □ Yes □ No □ Estimated Due Date: _____

Do you have problems with self-care or mobility issues? □ Yes □ No (Mark that apply)

□ Eating □ Bathing □ Toileting □ Dressing □ Getting up from laying or sitting position □ Walking

Patient's Signature: _____ **MD Initials:** _____

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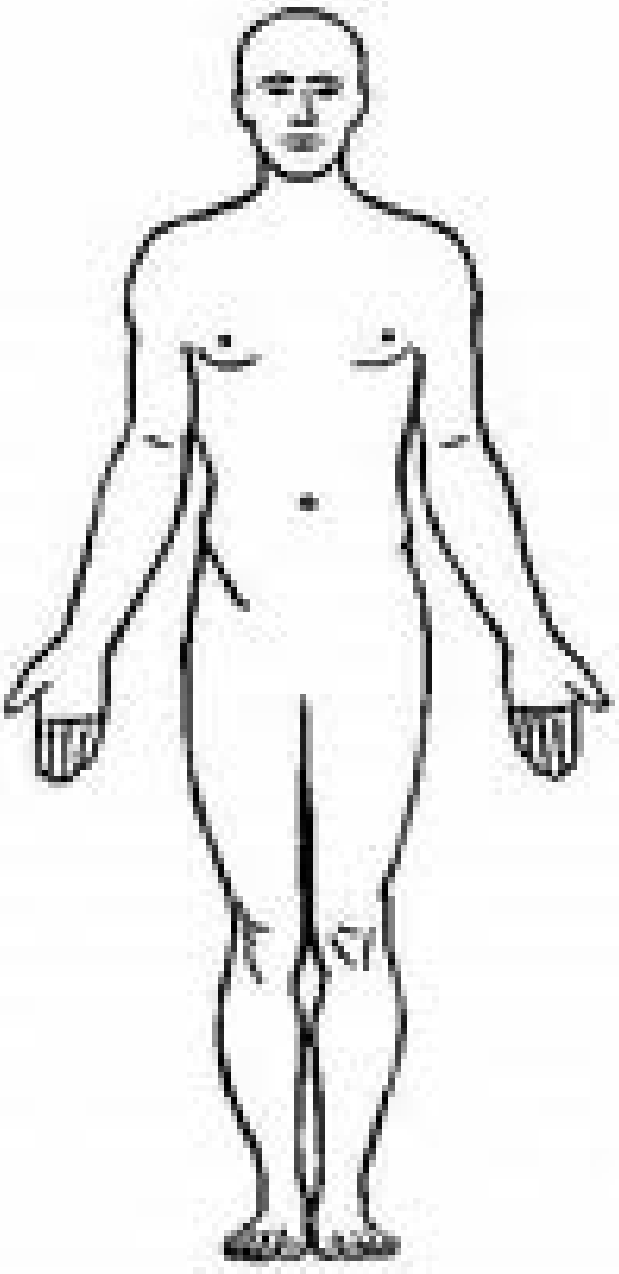
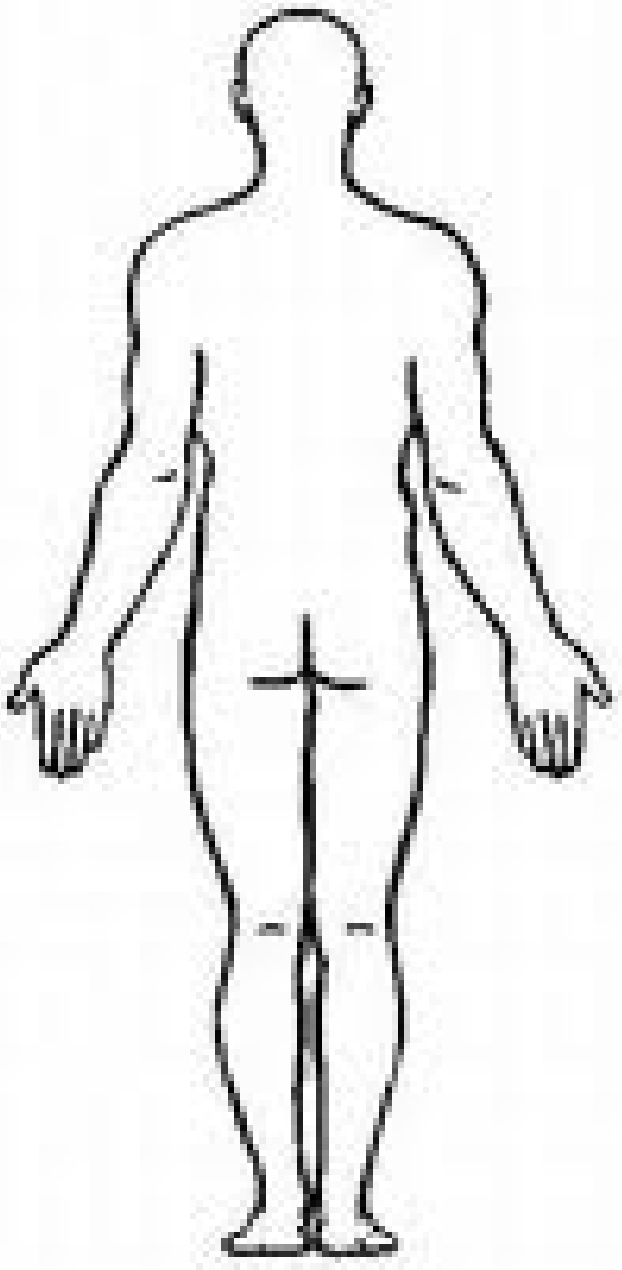
Pain Diagram





PATIENT NAME: _____

DATE: _____

MEDICAL RECORD#: _____

PLEASE INDICATE WHERE PAIN OR PROBLEM IS.

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Name: _____ DOB: _____ Date: _____

Smoking Status

If you are **13 or older** – please answer the following questions.

Smoking Status – **Please check all that apply**:

- ☐ I currently smoke every day
- ☐ I currently smoke on some days
- ☐ I am a former smoker
- ☐ I have never smoked
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Unknown if I have ever smoked
- ☐ I use / do not use tobacco

Fall Risk Assessment

If you are aged **65 and older**:

1. Have you fallen in the last year? ☐ YES ☐ NO
2. If yes, how many times? _____
3. Did you sustain any injuries from falling and if so, what?

   _____

   _____

   _____

   _____

4. Have you cut back on your activities because you are unsteady?

   _____

   _____

   _____

   _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself	0	1	2	3
	Add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	Total			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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