Patient Name:

DOB:

MR #:

University of Wisconsin Hospital and Clinics
600 Highland Avenue Madison, WI 53792

INITIAL PATIENT QUESTIONNAIRE-REHABILITATION

The clinic is located at 6630 University Ave. Middleton, WI 53562

Date: _____

Patient Address: _____

Home Phone: _____ Work Phone: _____

Age: _____ Height: _____cm/inches Weight: _____ kg/lbs ☐ Male ☐ Female

Referring Physician's Name: _____ Physician Phone: _____

Physician Address: _____

Type of Practice (Internist, Surgeon, etc.): _____

CHIEF COMPLAINT:
Do you have-

Neck pain	☐ Yes ☐ No	Upper back pain	☐ Yes ☐ No
Shoulder pain	☐ Yes ☐ No	Low back pain	☐ Yes ☐ No
Arm pain	☐ Yes ☐ No	Hip/Leg pain	☐ Yes ☐ No

Any other complaints: _____

If more than one area, which is worse? _____

How long have you had this problem? _____

Did your symptoms follow an injury ? _____ If yes, please indicate: ☐ Work ☐ Auto accident ☐ Other

Describe: _____

Circle your least and greatest pain levels over the past two weeks:

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

Describe your pain (check all that apply):

☐ Constant	☐ Deep	☐ Dull	☐ Sharp	☐ Intermittent	☐ Throbbing
☐ Stiffness	☐ Aching	☐ Shooting	☐ Cramping	☐ Burning	☐ Stabbing

Is your pain worse (check one)

☐ At night	☐ In the morning	☐ End of the shift/day
☐ No difference between day and night		☐ On a wet/cloudy day

Patient Name:

DOB:

MR #:

The clinic is located at 6630 University Ave. Middleton, WI 53562

University of Wisconsin Hospital and Clinics
600 Highland Avenue Madison, WI 53792
INITIAL PATIENT QUESTIONNAIRE-REHABILITATION

Indicate which of the following activities increase (I) or decrease (D) your pain

When I first get out of bed	_____	Standing	_____
Getting up	_____	Walking	_____
Sitting	_____	Bending back	_____
Lying on my back/side	_____	Lying on stomach	_____
Leaning forwards	_____	Coughing/Sneezing	_____
Lifting/bending forwards	_____	Twisting	_____
Straining	_____	Reaching over	_____
Look up/turn head sideways	_____	Washing/combing hair	_____
Climbing stairs/walking up ramp	_____	Going down stairs/ramp	_____
Long car rides	_____	Other _____	_____

Have you had neck/back symptoms before? ☐ Yes ☐ No

Have you had previous back or neck surgery? ☐ Yes ☐ No If yes, describe: _____

Have you had prior episodes of back symptoms for which you received Worker's Compensation? ☐ Yes ☐ No

Is the purpose of this exam to determine disability status for the government or an insurance agency? ☐ Yes ☐ No

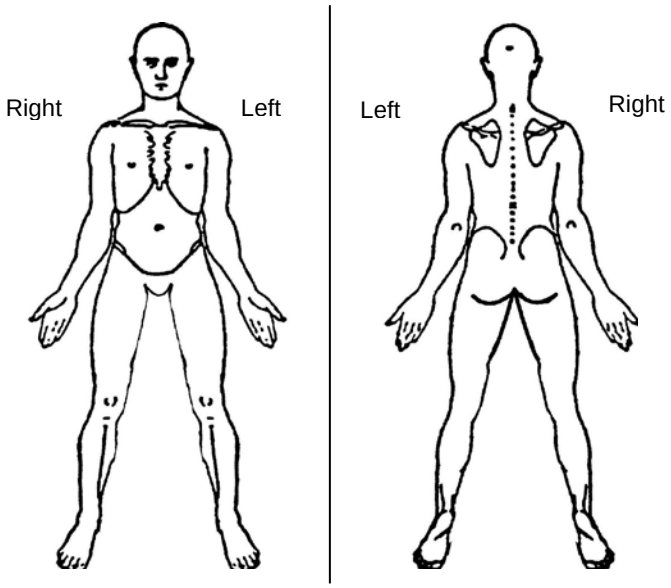
Are you currently receiving any type of financial compensation for your back problem? ☐ Yes ☐ No

Do you have an attorney for your back problem? ☐ Yes ☐ No

Mark in the areas of your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below:

PAIN = XXXXXXXXX

NUMBNESS = OOOOOO



Pain Diagram

Patient Name:

DOB:

MR #:

University of Wisconsin Hospital and Clinics
600 Highland Avenue Madison, WI 53792
INITIAL PATIENT QUESTIONNAIRE-REHABILITATION

The clinic is located at 6630 University Ave. Middleton, WI 53562

Date Location

MRI: _____

CT Scan: _____

Myelogram: _____

Bone Scan: _____

EMG: _____

Xrays: _____

PREVIOUS TREATMENT:
Put a check next to each type of treatment you have had for your back/neck in the past. Then check the column that best describes the effect of the treatment.

Treatment	(✓) if you have had this	Did it make things (✓) Better	Worse	No change
Hot packs/ice	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Massage	_____	_____	_____	_____
TENS/Electrical Stimulation	_____	_____	_____	_____
Yoga/Tai-Chi	_____	_____	_____	_____
Exercises	_____	_____	_____	_____
Traction	_____	_____	_____	_____
Bed Rest	_____	_____	_____	_____
Pool Therapy	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____
Injections	_____	_____	_____	_____
Braces/Splints	_____	_____	_____	_____
Medication	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Chiropractic Adjustments	_____	_____	_____	_____

MEDICAL HISTORY: Have you ever had:

☐ AIDS or HIV testing ☐ Phlebitis or blood clots ☐ Kidney Stones ☐ Asthma/Breathing problems
☐ Stroke ☐ Arthritis ☐ Cancer ☐ Thyroid trouble
☐ Seizures ☐ Radiation/Chemotherapy ☐ Kidney Infections ☐ Ulcer ☐Heart Attack
☐Migraine or other severe head pain ☐ Tuberculosis ☐ High Blood Pressure
☐ Diabetes ☐ Hepatitis ☐ Chronic Fatigue Syndrome ☐ Fibromyalgia
☐ Other: _____

Patient Name:

DOB:

MR #:

University of Wisconsin Hospital and Clinics
600 Highland Avenue Madison, WI 53792
INITIAL PATIENT QUESTIONNAIRE-REHABILITATION

The clinic is located at 6630 University Ave. Middleton, WI 53562

REVIEW OF SYSTEMS: (✓) all that apply.

Constitutional
Fever _____
Chills _____
Night sweats _____
Weight loss _____
Loss of appetite _____

Allergy/Immune
Drug allergy _____
Seasonal allergy _____
Food Allergy_____
Iodine allergy _____
Transplant _____

Neurological
Paralysis _____
Tremors _____
Spasticity _____
Seizures _____
Muscle atrophy _____

Musculoskeletal
Joint stiffness/swelling _____
Muscle pain/swelling _____
Fatigue _____
Fractures _____

Hemo-lymphatic
Anemia _____
Excessive bleeding _____
Easy bruising _____
Lymphoma _____
Leukemia _____
Cancer _____
Lymph node swelling _____

CV/Respiratory
Shortness of breath _____
Wheezing _____
Cough _____
Coughing up blood _____
Chest Pains _____
Palpitations _____
Leg swelling _____

Gastrointestinal
Difficulty swallowing _____
Heartburn _____
Nausea/vomiting _____
Constipation _____
Diarrhea _____
Blood in stools _____
Stomach pain _____

Endocrine
Obesity _____
Thyroid Disorder _____
Diabetes _____
Menopause _____
Menstrual irregularities____
Pelvic pain _____
Addison's disease _____

HENT
Loss of vision _____
Eye Redness _____
Headaches_____
Dizziness _____
Glaucoma _____

Skin/Integumentary
Rash _____
Ulcer _____
Eczema _____
Hives _____

Genitourinary
Pain urinating _____
Incontinence _____
Blood in urine _____
Dribbling _____
Sexual Difficulties _____
Pregnant _____; LMP _____

Psychiatric
Poor sleep _____
Depression _____
Anxiety _____
Stress at work/home _____
Panic Spells _____

PAST SURGICAL HISTORY:

Year Operation Place Hospitalized

_____

_____

_____

_____

_____

If you had previous back surgery;

What were your symptoms before the surgery? (indicate **R** for right side, **L** for left side, **B** for both sides and circle all that applies)

Neck Pain _____ Shoulder pain/numbness/weakness _____ Arm pain/numbness/weakness _____

Wrist/hand pain/numbness _____ Back Pain _____ Hip/buttock/thigh pain/numbness/weakness _____

Leg pain/numbness/weakness _____ Ankle/foot pain/numbness/weakness _____

Urinary complaints _____ Bowel Complaints _____ Impotence _____ Walking/gait disturbances _____

Balance/falls/clumsiness _____

Patient Name:

DOB:

MR #:

University of Wisconsin Hospital and Clinics
600 Highland Avenue Madison, WI 53792
INITIAL PATIENT QUESTIONNAIRE-REHABILITATION

The clinic is located at 6630 University Ave. Middleton, WI 53562

Did your symptoms improve after surgery? _____ If yes, how long afterwards? _____

Did you get worse after surgery? _____ If yes, explain: _____

Were you released back to work after surgery? _____ If so, when? _____

ALLERGIES:

Name of medicine/substance Type of reaction Date

_____

_____

_____

MEDICINES: List all medicines that you have taken recently. Include vitamins and non-prescription medicine.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

FAMILY HISTORY:

Spinal Problems ☐ Yes ☐ No If yes, describe: _____
Bleeding Disorders ☐ Yes ☐ No If yes, describe: _____
Heart Disease ☐ Yes ☐ No If yes, describe: _____
Cancer ☐ Yes ☐ No If yes, describe: _____
Diabetes ☐ Yes ☐ No If yes, describe: _____

SOCIAL HISTORY:

How many years of schooling ? (circle one)

Less than high school high school graduate technical school diploma 1-3 years of college
College graduate post graduate or professional degree

Marital Status: Single _____ Married _____ Divorced _____ Remarried _____ Widowed _____
Separated _____

How many years? _____ Number of children? _____ Ages: _____

Who lives with you at home? _____

Working status: ☐ Working ☐ Not Working ☐ Student ☐ Disabled ☐ Retired

Primary Occupation: _____ Employer: _____

Patient Name:

DOB:

MR #:

The clinic is located at 6630 University Ave. Middleton, WI 53562

University of Wisconsin Hospital and Clinics
600 Highland Avenue Madison, WI 53792

INITIAL PATIENT QUESTIONNAIRE-REHABILITATION

How long have you worked at your present job? _____ If not working, last date worked: _____

Spouse's Occupation: _____

Have you ever smoked? ☐ Yes ☐ No Type/Amount: _____ Years: _____ If quit, when? _____

Amount of alcohol consumed in a typical week? _____ Cups of caffeinated drinks per day? _____

Have you used: ☐Marijuana ☐ Cocaine ☐ Heroin ☐ Other _____

Do you get any regular exercise? Describe: _____

Please complete this form and bring with you to your appointment. Our clinic is located at 6630 University Ave. Middleton, WI 53562

Completed by: _____ Date: _____

If not completed by patient, relationship to patient: _____

Reviewed by: _____ Date: _____ Time: _____