

Please fill each of these blocks with the appropriate information.

Name	Birth Date	Today's Date
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What is the reason your doctor sent you for treatment?

How long have you had this problem? (please give a date or length of time)

How did your problem start?

Result of a Specific Injury Gradually Other (please explain)

Have you been treated somewhere else for this problem? Yes No If yes, where and when?

Have you had surgeries in the past? Yes No If yes, where and when?

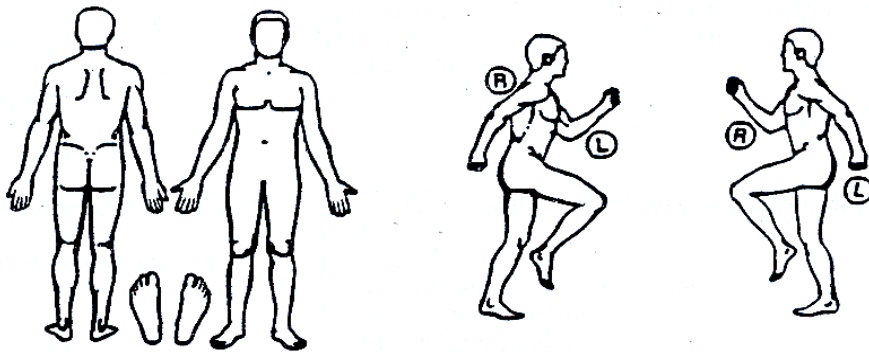
Please circle the level of your pain on the scale below with 0 being no pain and 10 being the worst pain.

0	1	2	3	4	5	6	7	8	9	10
mild discomfort			moderate pain				extreme pain			

Please circle the following words that describe your pain: Sharp Numb Tingling Dull

Burning Aching Variable Throbbing Shooting Constant Other (please describe)

Please indicate painful areas by shading the models below.



What positions or activities make your pain worse?

What positions or activities help to lessen your pain?

Are you allergic to any medications? If so, please list them.

Please list medications that you are currently taking

<u>Medication</u>	<u>Prescribing Physician</u>	<u>Phone # of Prescribing Physician</u>

Have you been in the hospital in the past 12 months for any problem? If so, please list where, when and why below

Hospital	Dates	Reason
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Hospital	Dates	Reason
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For the following sections, please place an X in front of all the answers that apply to you.

Which of the following medical conditions do you currently have? Give date as to when this/these occurred

- | | | | | |
|--|--|---|--|---------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Degenerative Joint Disease | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Carpal Tunnel Syndrome | |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Chronic Pain | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back Injury | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Depression, Anxiety and/or any other mental illness | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Heart Attack | |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Seizure Disorder | | |

Name: _____

Chart #: _____

<p>Where do you currently live?</p> <p><input type="radio"/> House</p> <p><input type="radio"/> Apartment</p> <p><input type="radio"/> Retirement Center</p> <p><input type="radio"/> Assisted Living Facility</p> <p><input type="radio"/> Personal Care Home</p> <p><input type="radio"/> Nursing Home</p> <p><input type="radio"/> Other (please explain)</p>	<p>Which of the following financial resources do you have?</p> <p><input type="radio"/> Employment</p> <p><input type="radio"/> Medicaid</p> <p><input type="radio"/> Medicare</p> <p><input type="radio"/> Insurance</p> <p><input type="radio"/> Pension</p> <p><input type="radio"/> Other (please explain)</p> <p><input type="radio"/> Social Security</p> <p><input type="radio"/> Social Security Disability</p> <p><input type="radio"/> Supplemental Security Income</p> <p><input type="radio"/> Short-term Disability From Work</p> <p><input type="radio"/> Long-term Disability From Work</p> <p><input type="radio"/> No Income</p>																																																																											
<p>How do you get to appointments?</p> <p><input type="radio"/> I drive myself</p> <p><input type="radio"/> A friend or family member takes me (if so, who?)</p> <p><input type="radio"/> I take the bus</p> <p><input type="radio"/> Other (please explain)</p>	<p>Which of the following people currently live with you?</p> <p><input type="radio"/> No one</p> <p><input type="radio"/> My spouse</p> <p><input type="radio"/> Family Members (please list them)</p> <p><input type="radio"/> Friends (please list them)</p> <p><input type="radio"/> Other (please explain)</p>																																																																											
<p>Which of the following equipment do you currently use?</p> <p><input type="radio"/> Oxygen</p> <p><input type="radio"/> Wheelchair</p> <p><input type="radio"/> Wheelchair Ramp</p> <p><input type="radio"/> Walker/Rolling Walker</p> <p><input type="radio"/> Crutches</p> <p><input type="radio"/> Hospital Bed</p> <p><input type="radio"/> Cane/Quadcane</p> <p><input type="radio"/> Bedside Commode</p> <p><input type="radio"/> Shower Bars</p> <p><input type="radio"/> Shower Chair/Bench</p> <p><input type="radio"/> None</p> <p>What other equipment do you think you might need?</p>	<p>Which of the following people help you the most? (check all that apply)</p> <p><input type="radio"/> Spouse</p> <p><input type="radio"/> Daughter</p> <p><input type="radio"/> Son</p> <p><input type="radio"/> Parents</p> <p><input type="radio"/> Other Family</p> <p><input type="radio"/> Friends/Neighbors</p> <p><input type="radio"/> Church friends</p> <p><input type="radio"/> Co-workers</p> <p><input type="radio"/> Home Health</p> <p>Do these people need some extra help to meet your needs? Example: Getting you to your appointment</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure</p>																																																																											
<p>With each of the following items, please indicate whether you do them alone or with help.</p>																																																																												
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<p>(Name of Mental Health Professional optional)</p> <p><input type="radio"/> Yes, I would like to meet and/or be contacted by a Social Worker regarding the above information.</p> <p><input type="radio"/> No, I do not wish to be contacted by a Social Worker at this time.</p>																																																																												
<p>Name of person that completed this form: (please print)</p>																																																																												
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<p>The Client/family does _____/does not _____ need social services intervention at this time.</p>																																																																												
<p>_____</p> <p>Social Worker's Signature</p>	<p>_____</p> <p>Date</p>																																																																											