Today's Date: __/___/___ Name:_____ DOB: ___/___/___

May we use your email to contact you? ○Yes ○No Email Address? _____

In order to assist in giving optimal care, please fill out the following. Thank you, in advance.

How are you feeling today?	Great	Good	Fair	Poor

How do you feel TODAY compared to ONE WEEK AGO?	Much Better	Better	Same	Worse	Much Worse

*****Since your last visit have you had: (check below and list dates and facilities below test).*****

Labs	X-ray	Bone Density	MRI	CT	ECHO	Ultrasound	TB Test

What are your major complaints since your last visit?

1. _____

2. _____

Please check (√) if you have experienced any of the following **over the last month**:

○Fatigue(C)	○Bruising/Bleeding(H)	○Congestion(R)	○Female Problems
○Fever (C)	○Swollen Glands(L)	○Chest Pain/Palpitation(C)	○Dizziness/Fainting(N)
○Weakness (C)	○Blurred Vision(E)	○Hypertension (C)	○Headache(N)
○Not Sleeping/Tired(C)	○Dry Eyes(E)	○Abdominal Pain(G)	○Problems Thinking(N)
○Weight Gain/Loss(C)	○Skin Rash(S)	○Constipation(G)	○Memory Loss(N)
○Loss of appetite(C)	○Dry Skin(S)	○Diarrhea(G)	○Depression(N)
○Dry Mouth(H)	○Ulcers/sores Skin(S)	○Heartburn or Gas(G)	○Anxiety(N)
○Ulcers/sores Mouth(H)	○Hair loss(S)	○Stomach Pain/ramps(G)	○Loss of Balance
○Hearing loss/Ringing(H)	○Cough(R)	○Dark/bloody Stools(G)	○Muscle Weakness
○Loss of smell/ taste(H)	○Wheezing(R)	○Nausea/Vomiting(G)	○Numbness/Tingling of Arms/Legs
○Trouble swallowing(H)	○Shortness of Breath(R)	○Problems Urinating	○Muscle Pain, Aches, Cramps

Are you having **Joint Pain** and/or **Swelling Joint(s)**?
Circle your worst joint, then check all that apply, indicating R=Right side, L= Left side, or B=Both or Bilateral.

Jaw	Mid Back	Shoulder(s)	Hand(s)	Hip(s)	Leg(s)	Ankle(s)	Fingers	Arms
Neck	Low Back	Elbow(s)	Wrist(s)	Knee(s)	Feet	Mid-Forefoot	Toes	_____

How long have your symptoms existed? 1 2 3 4 5 6 7 8 9	Hours	Days	Weeks	Months	Years

Severity of the condition?	Mild	Moderate	Severe

When does it occur?	During Activity	Upon awakening	Daytime	Night time	All of the time

How do you describe the pain?	Aching	Dull	Sharp	Catching	Throbbing/pulsating	Pain w/use

Are the symptoms?	Changing	Fluctuating	Improving	Resolved	Worse	Unchanged	Stable

Frequency?	Intermittent	Occasional	Persistent

Your symptoms are aggravated by:

Activity	Sleep	Reaching	Gripping	Standing	Walking	Climbing	Turning Neck
Arising From a Chair		Cold or Rainy Weather		Nothing	Other		

Your symptoms are relieved by:

Activity	Rest	Bracing	Cold	Heat	Sitting	Time	Joint Injections	Physical Therapy
Prescribed Medications		OTC Medications		Without Medications		Other		

Today's Date: _____ Name:_____ DOB: ___/___/___

Do you have morning stiffness? Yes No How long does it last?	30min	1hr	2 hrs	3 hrs

Do you have any stiffness after periods of inactivity Yes No?

Do you have any radiating pain? Yes No Where?	Upper Extremity	Lower Extremity	Spine

Pharmacy Name _____ Pharmacy Phone #: ( ) ____- _____ **Do you need any refills today**?

	List All Current Medications	Dose i.e.mg	How do you take Med?	Refill
1				
2				
3				
4				
5				

Since your last visit, have you? Please explain "Yes" answers below, or indicate other health issues that affect you:

Do you have any Allergies?	Yes	No
Do you have any new allergies or reactions to medications?	Yes	No
Have you had a side effect(s) of any drug?	Yes	No
Have you had a change of primary care or other doctor?	Yes	No
Have you seen any health care providers?	Yes	No
Have you had change(s) of arthritis drugs or other drugs?	Yes	No
Has another doctor given you a new medication, stopped or changed your existing medication?	Yes	No
Have you had an operation or new illness, a stay in a hospital?	Yes	No
Have you had a fall, broken bone, or other trauma?	Yes	No
Have you had an important new symptom?	Yes	No
Have you had a change in your family medical history?	Yes	No
Do you drink more than 2 alcoholic drinks a day?	Yes	No
Have you smoked cigarettes regularly?	Yes	No
Have you had change(s) of address?	Yes	No
Have you had change job or work duties, quit work, retired?	Yes	No
Have you had change(s) of marital status?	Yes	No
If yes, please specify:		

How much of a problem has UNUSUAL fatigue or tiredness been for you **OVER THE PAST WEEK**?

Fatigue is NOT a Problem	○ 0	○ 0.5	○ 1.0	○ 1.5	○ 2.0	○ 2.5	○ 3.0	○ 3.5	○ 4.0	○ 4.5	○ 5.0	○ 5.5	○ 6.0	○ 6.5	○ 7.0	○ 7.5	○ 8.0	○ 8.5	○ 9.0	○ 9.5	○ 10	Fatigue is a MAJOR Problem

How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) for at least 30 minutes?

>3 times a wk	1-2 times/wk(2)	1-2 times/month	Do not exercise regularly	Cannot exercise due to disability

Please check all factors that apply to your BMD (Bone Mineral Density)

○	Female	○	Caucasian or Asian descent	○	Low calcium intake	○	Height loss
○	Past menopause	○	Early estrogen deficiency	○	Low vitamin D intake	○	Steroid use
○	Advancing age	○	Smoker	○	Sedentary lifestyle	○	Decrease in BMD
○	Family history of osteoporosis	○	Excessive use of alcohol	○	Back pain	○	Low testosterone (men)
○	Thin/small frame	○	Last BMD	○	Taken Medrol /Prednisone	○	Confirmed fracture

Are you interested in a Patient Fitness, Weight loss, or Wellness Classes? Email? _____

Do you have any comments, complaints, or commendations, if so please list:

_____

_____

Today's Date: ___/___/___ Name:_____ DOB: ___/___/___

HEALTH ASSESMENT QUESTIONAIRE

DRESSING & GROOMING - Are you able to: Dress yourself, including tying shoelaces and doing buttons? Shampoo your hair?

Without any difficulty	With some difficulty	With much difficulty	Unable to do

ARISING - Are you able to: Stand up from a straight chair? Get in and out of bed?

Without any difficulty	With some difficulty	With much difficulty	Unable to do

EATING Are you able to: Cut your meat? Lift a full cup or glass to your mouth? Open a new milk carton?

Without any difficulty	With some difficulty	With much difficulty	Unable to do

WALKING Are you able to: Walk outdoors on flat ground? Climb up five steps?

Without any difficulty	With some difficulty	With much difficulty	Unable to do

Please check any AIDS OR DEVICES that you use for any of these activities:	O Cane	O Walker	O Crutches	O Wheelchair
O Built-up or special utensils	O Devices for dressing (button hook, zipper pull, shoe horn, etc.)			O Other:

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

O Dressing and grooming	O Arising	O Eating	O Walking

HYGIENE Are you able to: Wash and dry your body? Take a tub bath? Get on and off the toilet?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do

REACH Are you able to: Reach and get down a 5-pound object (such as a bag of sugar) from just above your head? Bend down to pick up clothing from the floor?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do

GRIP Are you able to: Open car doors? Open jars which have been previously opened? Turn faucets on and off?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do

ACTIVITIES Are you able to: Run errands and shop? Get in and out of a car? Do chores such as vacuuming or yard work?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do

Please check any AIDS OR DEVICES that you usually use for any of these activities:

O Long-handled appliances in bathroom	O Raised toilet seat	O Bathtub bar	OBathtub seat
O Long-handled appliances for reach	O Jar opener (for jars previously opened)	O Other	

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

O Hygiene	O Reach	O Gripping and opening things	O Errands and chores

How much pain have you had because of your condition OVER THE PAST WEEK?

No Pain	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	**Worst Pain Possible**
	0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10	

Can you walk two miles or three kilometers, if you wish?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do

Do you participate in recreational activities and sports as you would like, if you wish?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do

Do you get a good night's sleep?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do

How do you deal with feelings of anxiety or being nervous?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do

How do you deal with feelings of depression or feeling blue?

O Without any difficulty	O With some difficulty	O With much difficulty	O Unable to do