PM&R Consultation/Evaluation New Patient Information Form

Name _____ Date: _____

Pulse: _____ BP _____ RR _____ Temp _____ Height _____ Weight _____

Medications: _____ Allergies: _____

_____ _____

_____ _____

Chief Complaints:

History of Present Illness:

Diagnostic Studies:

PATIENTS: Please complete THIS SECTION and the NEXT PAGE…

Previous Medical History:

Hypertension	y	n	Circulatory	y	n
Diabetes	y	n	Neck	y	n
Cardiac ds	y	n	Back	y	n
Asthma/COPD	y	n	Pinched nerve/neuropathy	y	n
Gastrointestinal/PUD	y	n	Thyroid	y	n
Cancer	y	n	Other	y	n

Previous Surgical History:

Tonsillectomy/Adenoidectomy	y	n	Gyn/C section	y	n
Gallbladder	y	n	Orthopedic	y	n
Hernia	y	n	Cardiac/pacemaker	y	n
Appendectomy	y	n			

Social History:

Occupation/Student	Smoking	Housing
Married/Single	Alcohol	Stairs
Lives alone/With	DrugsFunctional History:	
Transfers		
Amb/Gait aide	ADIs	

PATIENTS: Please complete THIS PAGE

FAMILY MEDICAL HISTORY:

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
SIBLINGS	_____	_____	_____
SPOUSE	_____	_____	_____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in the space provided.

Constitutional Symptoms:
- Fever Y N
- Chills Y N
- Headache Y N
- Other _____

Eyes:
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other _____

Allergic/Immunologic:
- Hay fever Y N
- Drug allergies Y N
- Other _____

Neurological:
- Tremors Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Other _____

Endocrine:
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other _____

Gastrointestinal:
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other _____

Cardiovascular:
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other _____

Integumentary:
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other _____

Musculoskeletal:
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other _____

Ear/Nose/Throat/Mouth:
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other _____

Genitourinary:
- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other _____

Respiratory:
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other _____

Hematologic/Lympathic:
- Swollen glands Y N
- Blood clotting problem Y N
- Other _____

Psychologic:
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide Y N
- Other _____

Physician use only (Comments/Notes)

PHYSICAL EXAMINATION:

General appearance/build/age: Within normal range / other

Peripheral Vascular System:

Lymphatic:

Skin (lesions/ulcers/rashes/scars):

MUSCULOSKELETAL:

Leg Length Discrepancy: Yes _____ No _____
If yes, landmark ASIS _____ Umbilicus _____
Length (cm) Right _____ Left _____

Leg Circumferences:
Thigh Right _____ Left _____ cm above superior pole patella _____
Calf Right _____ Left _____ cm below superior pole of patella _____

Range of motion Upper Extremity

	RIGHT (degrees)	LEFT (degrees)
Shoulder Flexion		
Shoulder ER		
Shoulder IR		
Elbow Extension		
Elbow Flexion		
Wrist Extension		
Wrist Flexion		

Lower Extremity

	RIGHT (degrees)	LEFT (degrees)
Hip Flexion		
Hip ER		
Hip IR		
Knee Extension		
Knee Flexion		
Ankle Dorsiflexion		
Ankle Plantarflexion		

Cervical Spine:

Posture: _____

Areas of tenderness: _____

ROM (%FROM):	Flex _____	Ext _____
Rotation	R _____	L _____
Side Bend	R _____	L _____
Spurling's	R _____	L _____

Lumbar Spine:

Posture: _____

Areas of tenderness: _____

ROM (%FROM):	Flex _____	Ext _____
Rotation	R _____	L _____
Side Bend	R _____	L _____
Flip Test	Pos. _____	Neg. _____
SLR	R _____	L _____
Rotation	Pos. _____	Neg. _____
Axial Comp.	Pos. _____	Neg. _____
FABER	R _____	L _____
Active SLR	R _____	L _____
SLR	R _____	L _____
Sciatic Notch	R _____	L _____

Shoulders:

Atrophy: Yes _____ No _____

If yes, where? _____

Tenderness: _____

Impingement sign R _____ L _____

Other Tests

_____

_____

_____

Neurological

Sensation Intact to light touch Yes _____ No _____

If no, then where? _____

Deep Tendon Reflexes

	RIGHT	LEFT
Biceps		
Triceps		
BR		
Knee		
Ankle		
Babinski		

Motor Strength

Upper Extremity

	RIGHT (out of 5)	LEFT (out of 5)
Shoulder Flexion		
Shoulder ER		
Biceps		
Triceps		
Wrist Extension		
Wrist Flexion		
Hand Intrinsics		
Hand Grasp		

Lower Extremity

	RIGHT (out of 5)	LEFT (out of 5)
Hip Flexion (SLR)		
Hip Flexion (Knee Flex)		
Hip Abduction		
Hip Extension		
Quads		
Hamstrings		
Ankle Dorsiflexors		
Extensor Hallicus Longus		
Ankle Plantar Flexion		

Gait

Normal? Yes _____ No _____

If no, then describe gait deviations:

Without shoes/devices:

_____

_____

_____

With shoes/devices:

_____

_____

_____

Impression / Diagnosis:

Plan:

Next apt: _____Days _____Weeks _____Months Signature:_____