Columbia University Medical Center

Rehabilitation and Regenerative Medicine IntakeForm: Follow-up

Patient Name: ____________________

Date of Birth: ____/____/____ **Age:** ____ **MR#:**________________

Phone:

Today's Date____/____/____

Primary MD:

Referred By:

CC: **What problem/issue brings you here today?**

HPI: **Since your last physician visit, are your symptoms …**	Better	Worse	Same				
If better, by how much on a scale of 0-100%? (if 0 was the way you were and 100% was completely normal)							%
What makes it *worse*?	walking	sitting	standing	lying down	nothing	exercise	Other:
What makes it *better*?	walking	sitting	standing	lying down	nothing	exercise	Other:
What do you want to accomplish from today's visit?	Diagnosis	Treatment Options	X-ray	MRI	Med	Review Test	Injection
If currently in physical therapy / chiropractic, about how many visits have you had?	N/A						
If you had an injection since last visit, was it helpful?	N/A	No	Yes	Yes, but only for ____ days / weeks / months			

Please make a *mark on the line* below to indicate the level of discomfort you have today.

No Pain ________________________________ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

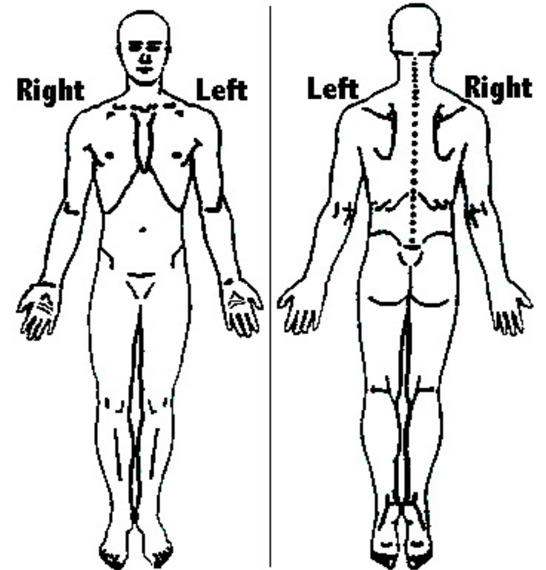
Please describe what the pain feels like: Achy, Burning, Cramping, Stabbing, Stiff, Tingling, Numbness, Dull, Tight, Pulling

Please describe the time course of your pain: Constant, Comes and goes, Getting worse, Getting better, Staying about the same

Medical/Surgical History: **Any *New Medical* problems, *Surgeries*, or *Allergies*** since your last physician visit? (if yes, please describe)	No	Yes
Medications:		
Family History: **Any *New Family* medical problems** (siblings, parents, children only) since your last visit? (if yes please describe)	No	Yes
Social History: **What do you do for exercise?**		

Tobacco use (cigarette, cigar, pipe, chew):	Current	Quit	Never
Number of alcoholic beverages per week?			
Occupation:			

Please shade all locations you have pain or discomfort



Employment status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent	Not working	Retired

Review of Systems

Fevers, unintentional weight change?	Yes	No
Vision change, double vision?	Yes	No
Difficulty swallowing, headaches?	Yes	No
Chest pain, palpitations?	Yes	No
Shortness of breath, wheezing, cough after exercise?	Yes	No
Nausea, vomiting, black stools, loss of control of stools?	Yes	No
Loss of control of urine, urinary frequency or urgency?	Yes	No
New rashes or psoriasis or skin lesions?	Yes	No
Dizziness, weakness, numbness, tingling?	Yes	No
Depressed mood, sleep problems, anxiety?	Yes	No
Current low back pain, other joint swelling or muscle pain?	Yes	No
♀ **Are you pregnant, trying to get pregnant or breastfeeding?**	Yes	No
♀ **Last menstrual period date: Periods regular?**	Yes	No

Patient's Signature:________________________

Physician Initials/Date: ____/____/____