Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

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☐ SCQ

Welcome to Rehabilitation Medicine!

Please indicate the physician you are seeing today: **TODAY'S DATE**: _____

- ☐ **Jaclyn Bonder, MD**
- ☐ **Alfred Gellhorn, MD**
- ☐ **Victoria Harrison, MD**
- ☐ **Chi Chang David Lin, MD**
- ☐ **Other: _____**
- ☐ **Michael O'Dell, MD**
- ☐ **Jesuel Padro-Guzman, MD**
- ☐ **Jaspal Ricky Singh, MD**
- ☐ **Michael Sein, MD**

BP_____ Puke_____
HT_____WT_____

PATIENT FIRST NAME_____ LAST NAME _____

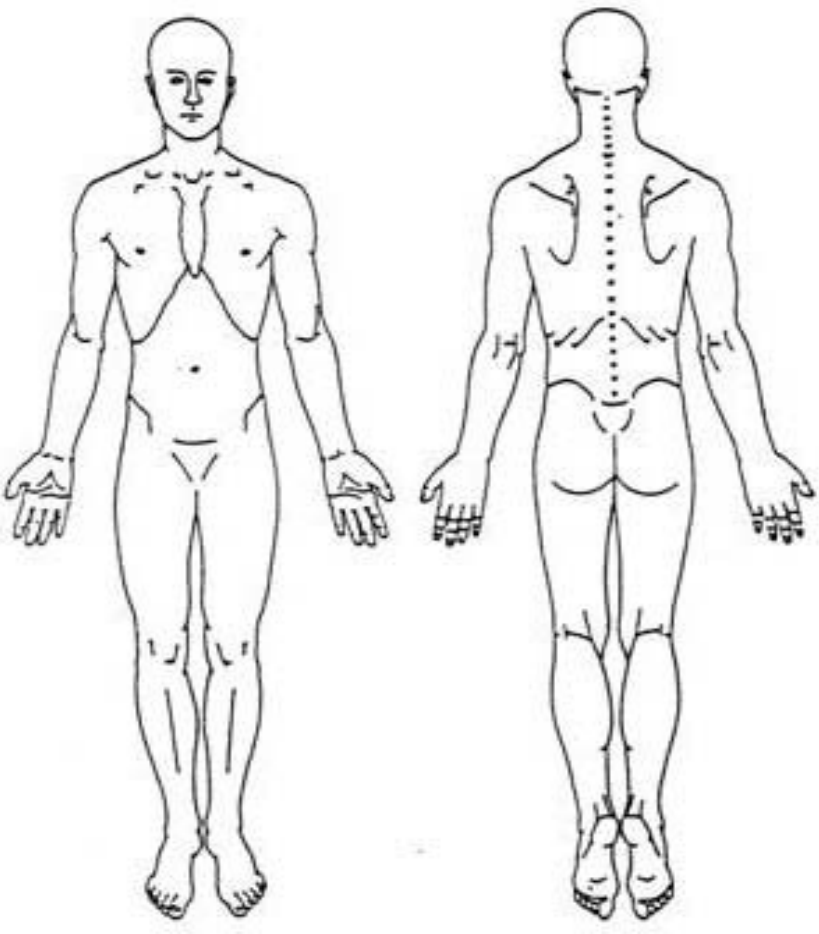
DATE OF BIRTH _____ AGE: _____ SEX: ☐MALE ☐FEMALE

REFERRED BY: _____ REFERRING DOCTOR'S PHONE #:_____

WHY ARE YOU HERE? _____

DURATION OF SYMPTOMS: _____ HOW DID IT BEGIN? _____

Please complete the pain drawing below by marking where you feel pain right now on the figures below.
(If you do not feel pain, please skip to page 2)



RATE YOUR PAIN ON A SCALE OF 0 TO 10
(0 = no pain 10 = extreme pain)

1. Right Now: 0 1 2 3 4 5 6 7 8 9 10

2. At Best: 0 1 2 3 4 5 6 7 8 9 10

3. At Worst: 0 1 2 3 4 5 6 7 8 9 10

4. What does the pain feel like (check all that applies)?

☐Sore	☐Aching	☐Burning
☐Shooting	☐Throbbing	☐Dull
☐Tender	☐Stabbing	☐Tingling
☐Sharp	☐Pulling	☐Cramping
☐Radiating	☐Unsure	☐

5. What makes it better (check all that applies)?

☐Heat	☐Cold	☐Bending Forward
☐Sitting	☐Standing	☐Bending Back
☐Walking	☐Twisting	☐Lying Down
☐Coughing	☐Sneezing	☐Weather Change
☐Sexual Intercourse		☐Nothing

6. What makes it worse (check all that applies)?

☐Heat	☐Cold	☐Bending Forward
☐Sitting	☐Standing	☐Bending Back
☐Walking	☐Twisting	☐Lying Down
☐Coughing	☐Sneezing	☐Weather Change
☐Sexual Intercourse		☐Nothing

7. Since the pain began, is it (check one): ☐getting better ☐getting worse ☐staying the same

8. Have you ever had pain in this area prior to this episode? ☐NO ☐YES If yes, when? _____

9. Have you had any recent falls? ☐ NO ☐ YES

10. How far can you walk? _____ Do you require an assistive device (e.g. cane, brace)? ☐ NO ☐ YES

11. Do you need help with household activities? ☐ NO ☐ YES

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS (check all that applies)**?**

☐ Easy Bleeding/Bruising	☐ Weight Change	☐ Breathing Problems	☐ Fever/Chills	☐ Heart Problems
☐ Stomach Problems	☐ Joint pain/ Swelling	☐ Morning Stiffness	☐ Weakness	☐ Skin Problems
☐ Bowel/Bladder Changes	☐ Night Pain	☐ Depression/Anxiety	☐ Numbness	☐ Tingling
☐ Shortness of Breath	☐ Vision Change	☐ Sleep Problems	☐ Headaches	☐ Chest Pain
☐ Rash	☐ Other _____			

AVE YOU HAD ANY OF THE FOLLOWING TESTS OR TREATMENTS FOR YOUR CURRENT PROBLEM?

	NO	YES	Date(s)		NO	YES	Date(s)
X-RAYS	☐	☐	_____	**EMG (Nerve Test)**	☐	☐	_____
CT SCAN	☐	☐	_____	**BONE SCAN**	☐	☐	_____
MRI SCAN	☐	☐	_____	**INJECTION**	☐	☐	_____
SURGERY	☐	☐	_____	**PHYSICAL THERAPY**	☐	☐	_____
MEDICATIONS	☐	☐	_____				

If yes, list names of medications for current problem _____/_____

MEDICAL HISTORY

PAST MEDICAL PROBLEMS: _____

_____

PAST SURGERIES & DATES:_____

_____

NAME ALL CURRENT MEDICATIONS:_____

_____

LIST ANY MEDICATION ALLERGIES:_____

DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING? Shellfish☐ Iodine☐ Contrast/ IV Dye☐ Latex☐

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Family Member	Alive	Arthritis	Cancer	Heart Disease	Diabetes	Other
	Y N					
	Y N					
	Y N					

HAVE YOU RECEIVED THE PNEMONIA VACCINATION? YES☐ NO☐ DATE:____/____/____

HAVE YOU RECEIVED THE INFLUENZA IMMUNIZATION? YES☐ NO☐ DATE:____/____/____

SOCIAL HISTORY (Check all that applies)

☐ **Single** ☐ **Domestic Partner** ☐ **Married** ☐ **Divorced** ☐ **Widow/Widower**

☐ **Smoker _____packs per day** ☐ **Nonsmoker (if previous smoker quit date: _____)**

ALCOHOL CONSUMPTION: ☐**YES or NO**☐**If so, how many drinks in 1 week _____**

RESIDENCE: ☐**House** ☐**Apartment** ☐**Other** **(Stairs:**☐**YES**☐**NO)** **(Elevator**☐**YES**☐**NO)**

EMPLOYMENT STATUS: ☐**Full Time** ☐**Part Time** ☐**Retired** ☐**Student** ☐**Unemployed** ☐**Disability** ☐**Workers' Compensation**

If applicable, Occupation_____

Urinary Symptoms

Do you experience any of the following?

Urinary incontinence (leakage of urine or urinary accidents) ☐ **NO** ☐ **YES**

If YES: (check all that apply)

☐ With: coughing/sneezing/laughing/exercise ☐ Occurs suddenly without warning

☐ Started during pregnancy ☐ Started after delivery of my baby

☐ Occurs because I cannot walk well enough to get to the bathroom on time

Feeling like you suddenly need to urinate ☐ **NO** ☐ **YES**

Feeling you urinate too frequently ☐ **NO** ☐ **YES**: How many times per day? _____

Feeling like you cannot empty your bladder fully ☐ **NO** ☐ **YES**

Cannot start your urine stream ☐ **NO** ☐ **YES**

Wake up to urinate more than 2x per night ☐ **NO** ☐ **YES**: How many times per night? _____

Pain with urination ☐ **NO** ☐ **YES**

Gastrointestinal

Do you experience any of the following?

Fecal incontinence (leakage of feces or bowel accidents) ☐ **NO** ☐ **YES**

Difficulty holding bowel movements or gas ☐ **NO** ☐ **YES**

Constipation ☐ **NO** ☐ **YES:**

How many bowel movements / week?

_____

Do you have increased pain with bowel movements? ☐ **NO** ☐ **YES**

Does your pain improve after completing a bowel movement ☐ **NO** ☐ **YES**

Sexual History

Are you currently sexually active? ☐ **NO** ☐ **YES**

Do you experience pain with sexual intercourse? ☐ **NO** ☐ **YES**

If YES: (check all that apply)

☐ With initial penetration ☐ Deep pain during sex

☐ With orgasms ☐ Because of body/leg positioning

History of sexually transmitted disease? ☐ **NO** ☐ **YES**

History of sexual problems? (i.e. erectile dysfunction, inability to have an orgasm) ☐ **NO** ☐ **YES**

Additional Medical History

Do you have a history of?

Depression ☐ **NO** ☐ **YES**

Anxiety ☐ **NO** ☐ **YES**

If YES: Are you treated with medications?

☐ **Currently** ☐ **In the past** ☐ **Never**

Are you treated with counseling?

☐ **Currently** ☐ **In the past** ☐ **Never**

Do you have trouble sleeping? ☐ **NO** ☐ **YES**

If YES: (check all that apply)

☐ Difficulty falling sleep ☐ Difficulty staying asleep

☐ Because of pain ☐ Because of racing thoughts, worry, or other feelings

Have you ever:

Been abused? ☐ **NO** ☐ **YES**

Had an eating disorder? ☐ **NO** ☐ **YES**

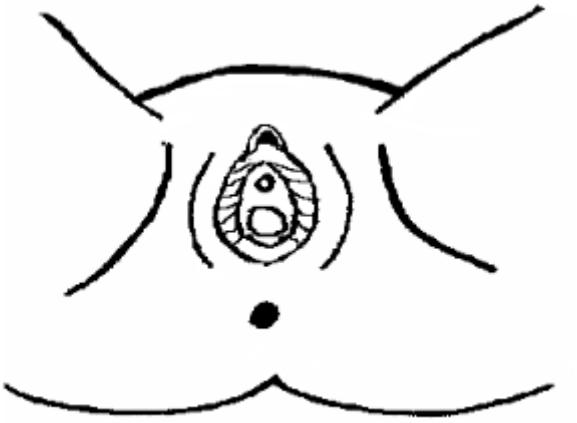
Felt unsafe at home or scared of your spouse/partner others? ☐ **NO** ☐ **YES**

FOR WOMEN ONLY (***MEN PLEASE SKIP THE REMAINING QUESTIONS***)

Vulvar / Perineal Pain

(pain outside and around the vagina and anus)

If you have vulvar pain, shade in the painful areas on the diagram below:



Information About Your Pain

What typed of treatments / providers have you tried in the past for your pain? (check all that apply)

☐ Acupuncture	☐ Family Practitioner	☐ Nutrition/Diet
☐ Anesthesiologist	☐ Herbal Medicine	☐ Physical Therapy
☐ Anti-seizure medications	☐ Homeopathic Medicine	☐ Psychotherapy
☐ Antidepressants	☐ Lupron, Synarel, Zoladex	☐ Psychiatrist
☐ Biofeedback	☐ Massage	☐ Rheumatologist
☐ Botox injection	☐ Meditation	☐ Skin Magnets
☐ Contraceptive pills/patch/ring	☐ Narcotics	☐ Surgery
☐ Danazol (Danocrine)	☐ Naturopathic Medication	☐ TENS unit
☐ Depo-provera	☐ Nerve blocks	☐ Trigger point injections
☐ Gastroenterologist	☐ Neurosurgeon	☐ Urologist
☐ Gynecologist	☐ Nonprescription medicine	☐ Other:_____

Obstetrical History

When was your last menstrual period? _____/_____/_____

Are you pregnant? ☐ **NO** ☐ **YES**; # of weeks_____

Number of pregnancies? _____

Number of children? _____

Ages of your children? _____

Are you currently breastfeeding? ☐ **NO** ☐ **YES**

Did you have back pain during your pregnancy? ☐ **NO** ☐ **YES**

How long was your last labor? _____

How long was your pushing phase? _____

What type of delivery/deliveries? (check all that apply)

☐ **Vaginal** ☐ **C-section** ☐ **Vacuum** ☐ **Forceps**

Have you ever had an episiotomy or tearing of vagina or rectum? ☐ **NO** ☐ **YES**

Any complications during pregnancy? (check all that apply)

☐ Hypertension	☐ Bleeding	☐ Contractions	☐ Diabetes
☐ Back pain	☐ Pelvic pain	☐ Bed rest	☐ Other: _____