NEW PATIENT QUESTIONNAIRE: Duke University Clinic 1L
CAROLYN KEELER, DO
PHYSICAL MEDICINE & REHABILITATION

Please take a moment and complete this form with as many details as you can remember to ensure a complete and accurate evaluation is performed to help you find some relief of your problems. Thank you.

Name:_____ DOB:_____
Referring Physician:_____ Age:_____

CURRENT PROBLEM(S): (Fill out as completely as possible)

Chief Complaint:_____

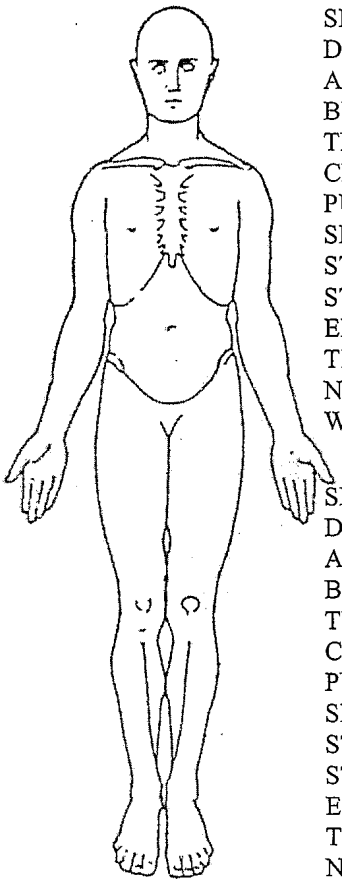
Onset: ☐Sudden ☐Gradual ☐Injury Date of Injury:_____

History of Problem:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous Trauma to affected area:_____
_____
_____
_____
_____
_____

Other Contributing Problems:_____
_____
_____
_____
_____
_____
_____
_____
_____

Please shade the areas of the diagrams below that correspond to your pain and circle any words that best describe your pain. You may draw arrows from the words to the areas they describe.



SHARP
DULL
ACHING
BURNING
THROBBING
CRAMPING
PULLING
SHOOTING
STABBING
STINGING
ELECTRIC
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SHARP
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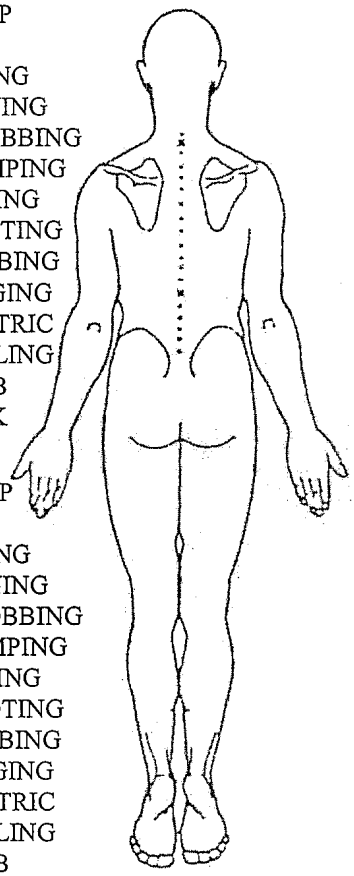

Pain Range (Best/Usual/Worst): (use a slash to mark each)

1	2	3	4	5	6	7	8	9	10

Frequency/Duration_____

Over time, the problem is:

☐Better ☐Worse ☐Unchanged ☐Waxes and Wanes ☐tends to flare up

Any problems holding your urine? ☐Yes ☐No Any problems holding your stool? ☐Yes ☐No

Worse	Better	No Diff	Action
( )	( )	( )	rest
( )	( )	( )	activity in general
( )	( )	( )	sitting
( )	( )	( )	driving
( )	( )	( )	standing
( )	( )	( )	walking
( )	( )	( )	reaching
( )	( )	( )	bending
( )	( )	( )	twisting
( )	( )	( )	coughing/sneezing
( )	( )	( )	straining at stools

What brings the pain on:_____
_____
_____
_____
_____

Associated symptoms:_____
_____
_____
_____
_____

What helps:_____
_____

EXAMINATIONS PERFORMED:

☐Plain X-rays ☐MRI ☐CT ☐EMG/NCS ☐Blood Tests ☐Other Tests

If other, please describe here:_____

_____

PREVIOUS TREATMENT:

Surgeries(related to this problem:)_____

_____

Injections:

☐Nerve Root ☐Facet Joint ☐Epidural Steroid ☐Sacroiliac Joint ☐Other

If other, please describe here:_____

Physical Therapy :

☐Ultrasound/Estim ☐Manual Therapy ☐Exercises ☐Aquatic Therapy

Other Treatment:

☐Osteopathic ☐Chiropractic ☐Massage ☐Acupuncture ☐Other

If other, please describe here:_____

_____

_____

PAST MEDICAL HISTORY (conditions requiring medication and any serious illness):_____

_____

_____

_____

_____

SURGERIES (not related to this problem):_____

_____

FAMILY HISTORY (diabetes, high blood pressure, cancer, heart disease, stroke, arthritis, etc.):_____

_____

CURRENT MEDICATIONS:

Currently take	Dosage	Times per day	If taking for pain, is it helpful?

PRIOR MEDICATIONS (for current problem): Results/side effects

_____

_____

_____

_____

_____

ALLERGIES (Please list reactions):_____

_____

SLEEP: Hours/night_____ Do you:
☐Have trouble falling asleep ☐Have trouble staying asleep ☐Wake up because of pain ☐Feel rested
Do you use sleep aides: Yes No If yes, please list:_____
Concerns:_____

DIET: ☐Red Meat ☐Poultry ☐Fish ☐Eggs ☐Dairy ☐Junk Foods_____
Concerns:_____

COUNSELING: (any counseling, psychological, or psychiatric treatment for any reason)_____
_____
Any history of childhood physical/psychological trauma or abuse_____

SOCIAL HISTORY: ☐Single ☐Married ☐Widowed ☐Divorced Children_____
Family/Financial Stress:_____
Physical Activity/Exercise:_____
Hobbies/Interests:_____
Spirituality:_____
Do you smoke? ☐Yes ☐No If yes, when did you quit? _____ Packs/day_____# of years_____
Do you drink alcohol regularly? ☐Yes ☐No If yes, how often? (drinks/week) _____
Do you drink coffee/tea? ☐Yes ☐No If yes, how often? (cups/day)_____
Do you use any recreational drugs? ☐Yes ☐No If yes, please specify_____
Are there any substance abuse issues in your household? _____
Do you need/have assistance with self-care of household activities? ☐Yes ☐No
If yes, please describe:_____

WORK STATUS: Are you currently working?_____
☐Full Duty ☐Modified Duty ☐Off Work ☐Unemployed Date last worked_____
What is your occupation?_____
Are you involved in litigation with regard to your condition? ☐Yes ☐No

MEDICAL HISTORY: (PLEASE CIRCLE ANY CURRENT PROBLEMS OR MARK NEG)

Constitutional:	☐Neg. Fever, chills, night sweats, fatigue, weight loss or weight gain.
Cardiovascular:	☐Neg. Chest pains, palpitations, heart murmur, or circulatory problems.
Respiratory:	☐Neg. Cough, shortness of breath, or wheezing.
GI:	☐ Neg. Nausea, vomiting, constipation, diarrhea, ulcers, or dark stool.
GU:	☐Neg. Burning urination, blood in urine, dribbling, or poor stream.
Musculoskeletal:	☐Neg. Other significant joint or muscle pains.
Skin:	☐Neg. Rashes, lumps, sores, or itching.
Neurological:	☐Neg. Headaches, dizziness, loss of balance, or seizures.
Psychological:	☐Neg. History of anxiety, depression, psychosis, or suicidal thoughts.
Endocrine:	☐Neg. Diabetes, thyroid problems, or hormonal disorders.
Hematologic:	☐Neg. Anemia, easy bruising, blood disorders, or history of transfusion.
ENT:	☐Neg. Trouble swallowing, ears ringing, sinus, throat, or mouth infections.
Eyes:	☐ Neg. Double or blurry vision.
Other:	☐Neg. Pregnant (any chance), history of chemical exposures.