

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
 For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE **Physical Therapy Medical History Intake Form Neck Pain**

OTSG APPROVED (Date)

MOS/Occupation: _____
 Duty Station/Unit: _____
 When did symptoms start (date): _____
 Symptoms related to deployment? Yes-Combat Yes-NonCombat No
 Have you had these symptoms before? Yes No
 How did symptoms start? _____
 Symptoms are? Constant Come/Go Only with Activity
 Symptoms are? Getting worse Not Changing Getting Better
 List any medications or dietary supplements your are taking:

_____ None
 List any drug or latex allergies you are aware of: _____ None
 List Assistive Devices you use (crutches, braces, shoe inserts): _____ None

Are you in the Personal Reliability Program (PRP)? Yes No
 Have you completed advanced medical directives? Yes No
 (aka: "living will") Information is available at front desk.
 Do you have difficulties with? (check all that apply)
Communication Vision None
Speech Hearing Other: _____

Mark an "X" on the lines below that best describes your response.

1. Which activity causes you the most pain / most trouble performing?

Function: Rate your ability to perform the *above* activity.
 0 1 2 3 4 5 6 7 8 9 10
 Unable to Perform No restrictions

2. Pain at WORST: Rate your highest pain level in past 72 hrs.

0 1 2 3 4 5 6 7 8 9 10
 No pain Worst pain Imaginable

3. Pain at BEST: Rate you lowest pain level in past 72 hrs.

0 1 2 3 4 5 6 7 8 9 10
 No pain Worst pain Imaginable

4. Impact: How distressing is this condition to you?

0 1 2 3 4 5 6 7 8 9 10
 No problem Devastating

Medical History:

	<u>Self</u>		<u>Family</u>	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No
Neurologic dz (MS, Parkinsons)?	Yes	No	Yes	No
Ulcers / GERD / Acid Reflux?	Yes	No	Yes	No
Kidney / Liver Disease?	Yes	No	Yes	No
Prior Surgeries:	Yes	No		

Other: _____

In the past 3 months have you had or do you experience:

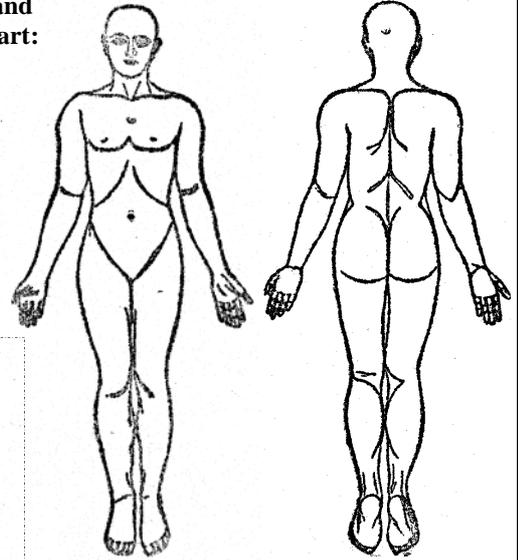
Change in your general health?	Yes	No
Fever / chills / sweats?	Yes	No
Unexplained weight change (>10lbs)?	Yes	No
Numbness or tingling?	Yes	No
Bowel / bladder incontinence?	Yes	No
Difficulty sleeping due to pain?	Yes	No
Unexplained Falls/Decreased balance?	Yes	No

Are you currently/Do you have:

Pregnant / Potentially Pregnant / Nursing?	NA	Yes	No
Often bothered by feeling down, depressed, or hopeless?		Yes	No
Often bothered by little interest or pleasure in doing things?		Yes	No
Under physical / emotional abuse?		Yes	No
Dietary or Nutritional Concerns?		Yes	No
Do you use tobacco products?		Yes	No

Indicate the location and type of pain on the chart:

Key:
 Ache/Dull: ^ ^ ^ ^
 Sharp/Stabbing: x x x x
 Numb / Tingling: o o o o
 Pins & Needles:
 Burning: = = = =
 Throbbing: / / / /
 Other Pain: - - - -



Therapist Notes:

PATIENT SIGNATURE / PREPARED BY:

DATE

DEPARTMENT/SERVICE/CLINIC

LRMC Physical Therapy
 APO AE 09180 486-8263

PATIENTS IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; rank; hospital or medical facility)

NAME (Last, First MI):

FMP / SSN (Sponsor): /

GRADE or RANK:

DOB:
 (Patients, dd-mmm-yyyy)

- | | |
|--|--|
| <input type="checkbox"/> HISTORY/PHYSICAL | <input type="checkbox"/> FLOW CHART |
| <input checked="" type="checkbox"/> OTHER/EXAMINATION OR EXAMINATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES | |
| <input type="checkbox"/> TREATMENT | |

NECK DISABILITY INDEX¹

Section 1: To be completed by patient

_____ AD _____ Non-Active Duty

Name: _____ Age: _____ Date: _____

Occupation: _____ Number of days of neck pain: _____ (this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your neck pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the line which most closely describes your current condition.**

Pain Intensity

- _____ I have no pain at the moment.
- _____ The pain is very mild at the moment.
- _____ The pain is moderate at the moment.
- _____ The pain is fairly severe at the moment.
- _____ The pain is very severe at the moment.
- _____ The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing, etc.)

- _____ I do not have to change the way I wash and dress myself to avoid pain.
- _____ I do not normally change the way I wash or dress myself even though it causes some pain.
- _____ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- _____ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- _____ Because of my pain I am partially unable to wash and dress without help.
- _____ Because of my pain I am completely unable to wash or dress without help.

Lifting

- _____ I can lift heavy weights without increased pain.
- _____ I can lift heavy weights but it causes increased pain
- _____ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.).
- _____ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- _____ I can lift only very light weights.
- _____ I can not lift or carry anything at all.

Reading

- _____ I can read as much as I want to with no pain in my neck.
- _____ I can read as much as I want to with slight pain in my neck.
- _____ I can read as much as I want with moderate pain in my neck.
- _____ I can't read as much as I want because of moderate pain in my neck.
- _____ I can hardly read at all because of severe pain in my neck.
- _____ I cannot read at all.

Headache

- _____ I have no headache at all.
- _____ I have slight headaches which come infrequently.
- _____ I have moderate headaches which come infrequently.
- _____ I have moderate headaches which come frequently.
- _____ I have severe headaches which come frequently.
- _____ I have headaches almost all the time.

(Don't forget to fill out the back side)

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Section 2 (con't): To be completed by patient

Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Work

- I can do as much as I want to.
- I can only do my usual work but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleep loss).
- My sleep is mildly disturbed (1-2 hour sleep loss).
- My sleep is moderately disturbed (2-3 hours sleep loss).
- My sleep is greatly disturbed (3-5 hours sleep loss).
- My sleep is completely disturbed (5-7 hours sleep loss).

Recreation

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some pain in my neck.
- I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I can't do any recreational activities at all.

Section 3: To be completed by physical therapist/provider

SCORE: _____ out of 50 (SEM 5, MDC 7)

Initial **F/U** _____ **weeks** **Discharge**

Number of treatment sessions: _____

Gender: Male Female

Diagnosis/ICD-9 Code: _____

¹ Adapted from Vernon H, Mior S. The Neck Disability Index: A Study of Reliability and Validity. Journal of Manipulative and Physiological Therapeutics 1991; 14(7): 409-415.