Mederi Health

SPECIALISTS IN HEALTH & WELLNESS

Patient Name: _____
Patient Phone Number: _____
Date of Birth: _____
Address: _____
Today's Date: _____

I) GOALS & EXPECTATIONS

What brings you to consult with me?

_____
_____

What do you think is the most important thing I can do to help you achieve your goals?

_____
_____

II) CHIEF COMPLAINT

When did your chief complaint start?

_____

What makes it feel better or worse?

_____

Do you have a secondary complaint?

_____

What makes your secondary complaint better or worse?

_____

III) CURRENT STATUS

Very much (80%) better	Much (50%) better	Minimally (20%) better	No Change	Minimally (20%) worse	Much (50%) worse	Very Much (80%) worse

IV) PAIN

1a. Please indicate your USUAL level of pain during the past week (0-10):

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

1b. Please indicate your WORST level of pain during the past two weeks (0-10):

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

2a. Are you taking and MEDICATION (PAIN KILLERS) for your symptoms (Circle one):
Never Rarely Sometimes Every day

2b. If you are taking MEDICATION (PAIN KILLERS) which applies
(Circle One - Or Skip 2b if answer to 2a was Never):
I am using them less I am taking the SAME amount I am using them more

2c. If you are taking MEDICATION (PAIN KILLERS) what are you taking:

_____

V) ACTIVITY TOLERANCE

1. Physical activity (in general) makes my pain worse

0 100% Disagree	1	2	3	4	5	6	7	8	9	10 100% Agree

2. What activities give you the most trouble?

_____

VI) HEALTH HISTORY

Has your MD ever said you have heart trouble?
☐Yes ☐No
Do you frequently have chest pains?
☐Yes ☐No
Do you often feel faint or have spells of severe dizziness?
☐Yes ☐No
Has your MD ever said you have high blood pressure)?
☐Yes ☐No
Do you have a bone or joint problem that could be made worse by a change in physical activity?
☐Yes ☐No
Are you currently taking any prescription medication?
☐Yes ☐No
If yes to previous question, what medication are you taking? _____
Do you suffer from allergies, not including seasonal?
☐Yes ☐No
If yes to previous question, what allergies do you suffer from? _____
Do you suffer from asthma?
☐Yes ☐No
Do you have ANY injuries past or present which we should no about?
☐Yes ☐No
Have you ever been in a car accident?
☐Yes ☐No
Have you ever had any surgeries?
☐Yes ☐No
Have you had any fractures?
☐Yes ☐No
If you answered yes to the previous questions regarding past injuries, accidents, surgeries, or fractures please elaborate below.

_____

_____

VII) LIFESTYLE QUESTIONS

1. Smoking

Never	Former	Current

If you are a current smoker, how many packs per day?

< 1	1	2	3	> 3

2. Nutrition

A. Weight in lbs: _____

B. Height in inches: _____

On a scale of 1-10, how would you rate your nutrition/diet?

1 Very Poor	2	3	4	5	6	7	8	9	10 Excellent

Do you eat vegetables daily?

☐Yes ☐No

Do you drink soda daily?

☐Yes ☐No

How many glasses of water do you consume daily (Circle your answer)?

1-3 4-6 7-9 10-12 >12

Do you feel drops in your energy level throughout day?

☐Yes ☐No

If yes to previous answer please specify when below.

_____

Do you drink coffee/tea or other caffeinated beverages?

☐Yes ☐No

If yes to previous question please give about you drink per day and specify if coffee, tea, or energy drinks.

_____

Are you currently taking any supplements? If yes please list below.

_____

_____

Alcohol consumption (Total number of alcoholic drinks consumed per week)

No Alcohol 1-21 >21

Social Participation (Please answer by checking which best applies to you. You may consider two or more statements to apply, but please check the one that most clearly describes how your issues affect your social life.)

☐ My social life is normal and gives me no extra pain
☐ My social life is normal, but increases the degree of pain
☐ Pain has no significant effect on my social life apart from my more energetic interest, ex: sport
☐ Pain has restricted my social life and I do not go out as often
☐ Pain has restricted my social life to my home
☐ I have no social life because of pain

VIII) WELLNESS QUESTIONS (ANSWER FOR HOW YOU FEEL TODAY)

1. Fatigue

Very Fresh	Fresh	Normal	More Tired than Normal	Always Tired

2. Sleep Quality

Very Restful	Good	Difficulty Falling Asleep	Restless Sleep	Insomnia

3. General Muscle Soreness

Feeling Great	Feeling Good	Normal	Increased Soreness/Tightness	Very Sore

4. Stress Levels

Very Relaxed	Relaxed	Normal	Feeling Stressed	Highly Stressed

5. Mood

Very Positive Mood	Generally Good Mood	Less Interested in Others and/or Activities than Usual	Snappiness at Family and/or Coworkers	Highly Annoyed, Irritable, or Down

IX) FITNESS

1. List your three most strenuous activities or workouts, duration of activity, level of exertion (RPE), frequency per week:

Activity 1: _____

Average Duration of activity (minutes): _____

Days/Week: _____

Rating of Perceived Exertion (RPE) for above activity:

0 Rest	1	2	3	4	5	6	7	8	9	10 Maximal Exertion

Activity 2: _____

Average duration of activity (minutes): _____

Days/Week: _____

Rating of Perceived Exertion (RPE) for above activity:

0 Rest	1	2	3	4	5	6	7	8	9	10 Maximal Exertion

Activity 3: _____

Average duration of activity (minutes): _____

Days/Week: _____

Rating of Perceived Exertion (RPE) for above activity:

0 Rest	1	2	3	4	5	6	7	8	9	10 Maximal Exertion