

Name: _____

Evaluation Date: _____

Cardiac Risk Factor Analysis

1. Age: _____ Date of Birth: _____
 2. Is there a history of heart attack or sudden death in your family before age 55 in male relatives or before age 65 in female relatives? Include parents, grandparents, siblings, aunts and uncles: _____
 3. Do you smoke? _____
 4. Do you have high blood pressure or are you currently taking medication to treat high blood pressure? _____
 5. Do you have high cholesterol (greater than 200) or low HDL cholesterol (less than 35)? _____
 6. Do you have diabetes? _____ if yes, insulin dependent or non insulin dependent? _____
 7. Do you regularly exercise or have any regular active recreational pursuits? _____
What is your current occupation? _____
-

Do you have an HDL level greater than 60? (Leave blank if unknown) _____

Do you have any known heart or lung disease, asthma? _____ Explain: _____

Name: _____

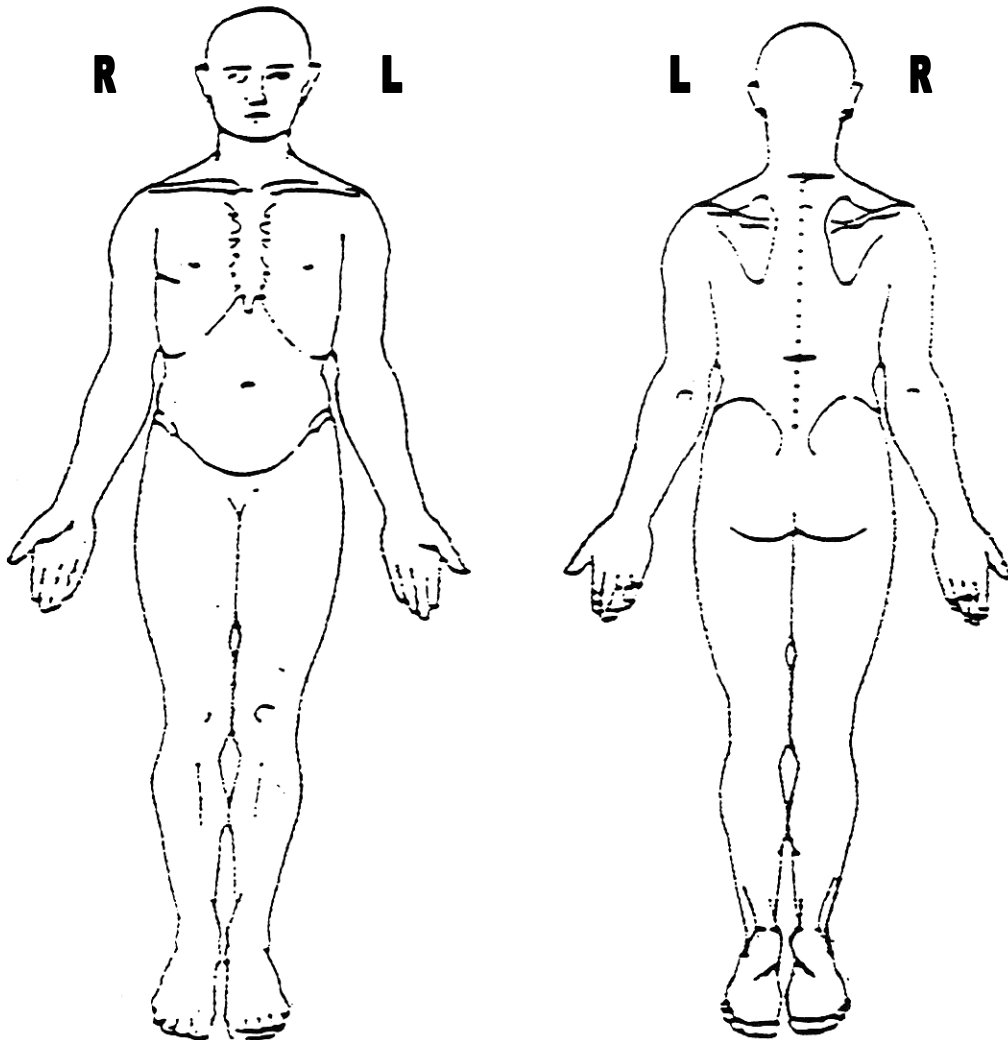
Evaluation Date: _____

1. BODY CHART:

Color in the area(s) on the body chart below according to where your pain is today. Only mark the area(s) we are treating.

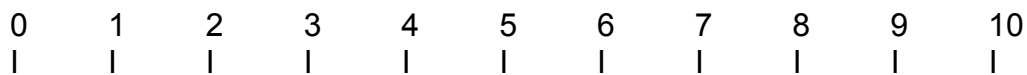
Shade lightly for mild pain. Shade darker for severe pain.

If you have numbness or tingling, fill in area with this: ////



2. PAIN LEVEL:

My current pain level is a # _____. (Use the pain scale below)



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MEDICAL HISTORY QUESTIONNAIRE

Current Medical History

1. What medications (prescription and over-the-counter) are you presently taking?

2. Circle any tests below that you have had recently and the approximate date tested. If any, what area(s)?

TEST	APPROX. DATE	AREA
X-rays		
CT scans		
MRIs		
EMGs		
Ultrasounds/Doppler		

3. Have you had any recent laboratory work done (urinalysis or blood tests)? Please include dates and area(s) treated:

Past Medical History

1. Have you had any recent or significant surgeries? If yes, Please list including dates:

Family History

1. Does your family have a history of any heart problems, cancer, high blood pressure, diabetes, arthritis or any other diseases? Please explain.

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General Health History

	Past History	Currently Have		Past History	Currently Have
Blackouts			Emphysema		
Cancer			Fainting Spells		
Polio			Heart Palpitations (extra or skipped beats)		
Cerebral Palsy			Kidney disease/Stones		
Chest Pain			Severe Anemia		
Coronary Bypass/Cardiac Surgery			Unexplained Fatigue		
Diabetes			Chronic Cough		
Epilepsy			Phlebitis		
Aneurysm			Prostate Disorder		
Heart Disease			Smoking Habit		
Low Blood Pressure			Swollen Ankles		
Metabolic Disease			Ulcers/Stomach problems		
Paralysis			Persistent Infection		
Peripheral Vascular Disease			Advice from a physician not to exercise		
Rheumatic Fever/Scarlet Fever			Hypoglycemia		
Glaucoma, Eye pressure			Urinary tract infection		
Abnormal EKG/ECG			Hepatitis/Jaundice		
Fixed Rate Pace Maker			Cirrhosis/Liver disease		
Seizures/Convulsions			Dizziness		
Shortness of Breath			Pneumonia		
Arthritis			Migraine headaches		
Asthma, Hay fever			Gout		
Chronic Respiratory Infection			Prostate disease(men)		
Varicose Veins			Gynecologic disorders(women)		
Allergies/Allergy to Bee Stings			Other		

Please list:

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PLEASE CHECK THOSE THAT APPLY

DO YOU HAVE DIFFICULTY WITH . . .

	YES	NO
1. Sitting for < 15 minutes	_____	_____
2. 15-30 minutes	_____	_____
3. 30-45 minutes	_____	_____
4. > 45 minutes	_____	_____
5. Standing for <15 minutes	_____	_____
6. 15-30 minutes	_____	_____
7. 30-45 minutes	_____	_____
8. > 45 minutes	_____	_____
9. Walking for < 15 minutes	_____	_____
10. 15-30 minutes	_____	_____
11. 30-45 minutes	_____	_____
12. > 45 minutes	_____	_____
13. Driving for < 15 minutes	_____	_____
14. 15-30 minutes	_____	_____
15. 30-45 minutes	_____	_____
16. >45 minutes	_____	_____
17. Getting in and out of a car	_____	_____
18. Getting up out of bed	_____	_____
19. Transferring from sit to stand	_____	_____
20. Transferring from stand to sit	_____	_____
21. Lifting / Bending	_____	_____
22. Twisting	_____	_____
23. Ascending stairs	_____	_____
24. Descending stairs	_____	_____
25. Walking up/down inclines	_____	_____
26. Dressing	_____	_____
(i.e., putting on socks, shoes, pants, pantyhose)	_____	_____
27. Wearing shoes (i.e., heels, flats, or larger shoes)	_____	_____
28. Controlling your gas pedal/brake/clutch	_____	_____
29. Housework	_____	_____
a) Light: dusting, picking up, "touch ups"	_____	_____
b) Moderate: dishes, cooking, making the bed	_____	_____
c) Heavy: vacuuming, laundry, washing windows	_____	_____
30. Falling asleep	_____	_____
31. Waking up with position changes	_____	_____
32. On the average, how often do you wake up due to pain? _____	_____	_____
33. Reading or working at a desk	_____	_____
34. Looking over your shoulder when driving	_____	_____

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SOCIAL WORKER FORM

We are interested in the total well being of our patients. In keeping with this philosophy, we feel that social worker intervention may sometimes be appropriate. During your rehabilitation, you, your physician, therapist, or our social worker might agree that this service may be helpful. The Social Worker is available by appointment to evaluate the social or vocational factors involved in your rehabilitation, to counsel and advise you on social problems arising from your illness or injury, and to make appropriate referrals for required services, if any. You may schedule a meeting with our social worker through the receptionist or through your therapist.

Please answer the following questions to assist us in determining whether you might benefit from social work or vocational consulting services.

1. Are you presently out of work because of your illness or injury?
Yes _____ No _____
2. Are you experiencing stress or related problems because of your illness or injury?
Yes _____ No _____
3. Are you receiving social work, psychological counseling or vocational counseling through your physician or insurance company?
Yes _____ No _____
4. Are you interested in speaking to the Social Worker?
Yes _____ No _____
5. Do you live alone?
Yes _____ No _____
6. Does someone else help take care of you?
Yes _____ No _____
7. Are you the primary caregiver for a spouse or family member?
Yes _____ No _____
8. Do your symptoms prevent you from performing any daily tasks?

Self-care (bathing, washing hair, etc.)

Yes _____ No _____

Driving

Yes _____ No _____

Grocery shopping

Yes _____ No _____

Preparing food

Yes _____ No _____

Housekeeping

Yes _____ No _____