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:_____

Medical History:	**Self**		**Family**	
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

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.

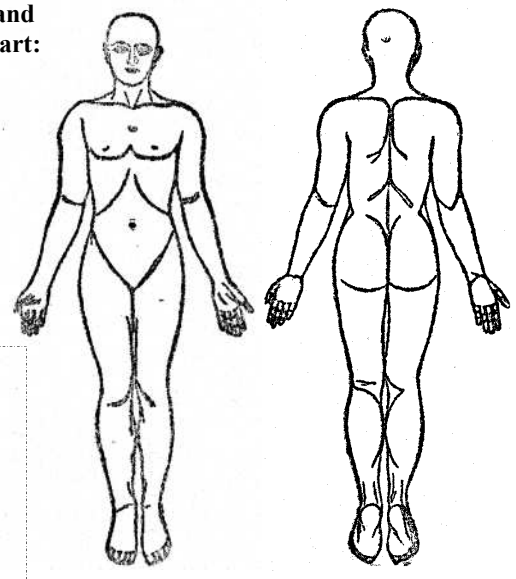
0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

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

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

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)

☐ **HISTORY/PHYSICAL** ☐ **FLOW CHART**

☒ **OTHER/EXAMINATION OR EXAMINATION** ☐ **OTHER** *(Specify)*

☐ **DIAGNOSTIC STUDIES**

☐ **TREATMENT**

DA FORM 1 MAY 78 4700

MCEUH OP 370-R, APR 96(Rev)
DA 4700 Master Rx Form, Updated 13-May-11

NECK DISABILITY INDEX[1]

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)

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 Indes: A Study of Reliability and Validitiy. Journal of Manipulative and Physiological Therapeutics 1991; 14(7): 409-415.