Welcome!

Weill Cornell Medicine
Rehabilitation Medicine

Please indicate the physician you are seeing today:

- ☐ Jaclyn Bonder, MD
- ☐ Nasim Chowdhury, MD
- ☐ Alfred Gellhorn, MD
- ☐ Victoria Harrison, MD
- ☐ Chi Chang David Lin, MD
- ☐ Leroy Lindsay, MD
- ☐ Vincent Miccio, MD
- ☐ Mike Mizrahi, DO
- ☐ Michael O'Dell, MD
- ☐ Michael Saulle, DO
- ☐ Michael Sein, MD
- ☐ Jaspal Ricky Singh, MD
- ☐ Vandana Sood, MD
- ☐ Jennifer Soo Hoo, MD
- ☐ Katherine Yao, MD

Please Note: All information is confidential and will become a part of your medical record. Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. PLEASE PRINT CLEARLY

Patient Name:	**Date of Visit:**
Date of Birth:	**Social Security Number:**
Gender: ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner
Home Address:	**Home Phone Number:** **Other Phone Number:**
Preferred Email Address:	**Emergency Contact Name and Number:** **Relationship to Patient:**
Primary Insurance Carrier:	**Insurance ID Number:**
Insurance Phone Number:	**Are you the Primary Insurance Policy Holder?** ☐ Yes ☐ No
If No, Please list the Name and Date of Birth of the Policy Holder:	
Does Your insurance plan require referrals for specialty visits? ☐ Yes ☐ No	**If YES, do you have a referral for today's visit?** ☐ Yes ☐ No

T. 212.746.1500 | F. 212.746.8303 | rehab@med.cornell.edu

Physician and Pharmacy Information

Referring Physician	Primary Care Provider
Name:	Name:
Phone:	Phone:
Fax :	Fax:

Were you referred for a Consultation?

☐ Yes ☐ No

Preferred Pharmacy

Name:

Phone:

Fax:

Did you sustain your injury on the job or during a motor vehicle accident?

☐ Yes ☐ No

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize the holder of medical information about me to release to my insurance and, if I am a Medicare patient, to the Centers for Medicare and Medicaid Services and its agents, any information necessary to determine these benefits or the benefits payable for related services. I request that payment of any benefits be made on my behalf to the provider of services. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for payment in full for these services including any amounts not paid by my insurance carrier such as Copayments, Deductibles, and other Non-covered services.

I understand that services deemed non-medically necessary are not covered by my insurance carrier and that I will be financially responsible for any such non-covered services.

Signature Date

T. 212.746.1500 | F. 212.746.8303 | rehab@med.cornell.edu

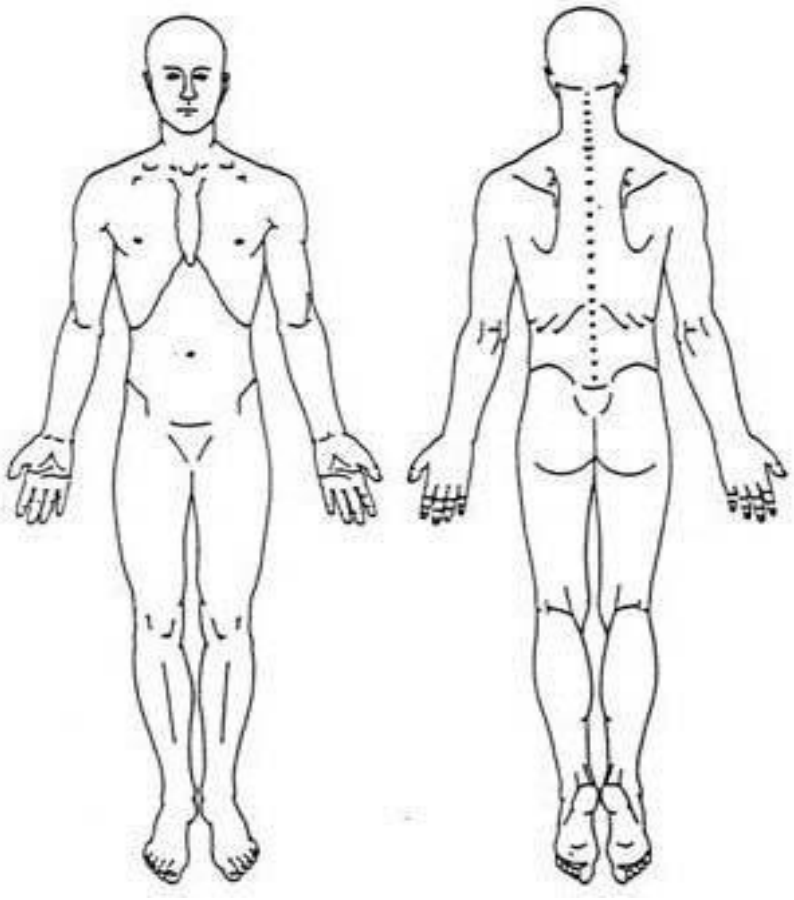
Weill Cornell Medicine
Rehabilitation Medicine

SCQ

BP_____ Pulse_____
HT_____WT_____

Patient Name:	Patient Date of Birth:
Why are you here today?	Referring Provider:
Duration of symptoms?	
How did it begin?	

Please complete the pain drawing below by marking where you feel pain right now on the figures below.
(If you do not feel pain, please skip to page 2)



RATE YOUR PAIN ON A SCALE OF 0 TO 10
(0 = no pain 10 = extreme pain)

1. Right Now: 0 1 2 3 4 5 6 7 8 9 10

2. At Best: 0 1 2 3 4 5 6 7 8 9 10

3. At Worst: 0 1 2 3 4 5 6 7 8 9 10

4. What does the pain feel like (check all that apply)?

☐ Sore ☐ Aching ☐ Burning
☐ Shooting ☐ Throbbing ☐ Dull
☐ Tender ☐ Stabbing ☐ Tingling
☐ Sharp ☐ Pulling ☐ Cramping
☐ Radiation ☐ Unsure

5. What makes it better (check all that applies)?

☐ Heat ☐ Cold ☐ Bending Forward
☐ Sitting ☐ Standing ☐ Bending Back
☐ Walking ☐ Twisting ☐ Lying Down
☐ Coughing ☐ Sneezing ☐ Weather Change
☐ Sexual Intercourse ☐ Nothing

6. What makes it worse (check all that applies)?

☐ Heat ☐ Cold ☐ Bending Forward
☐ Sitting ☐ Standing ☐ Bending Back
☐ Walking ☐ Twisting ☐ Lying Down
☐ Coughing ☐ Sneezing ☐ Weather Change
☐ Sexual Intercourse ☐ Nothing

7. Since the pain began, is it (check one): ☐ getting better ☐ getting worse ☐ staying the same

8. Have you ever had pain in this area prior to this episode? ☐ NO ☐ YES If yes, when? _____

9. Have you had any recent falls? ☐ NO ☐ YES

10. How far can you walk?

11. Do you require an assistive device (e.g. cane, brace)? ☐ NO ☐ YES

12. Do you need help with household activities? ☐ NO ☐ YES

Do you have any of the following symptoms (check all that apply)?

☐ Easy Bleeding/Bruising	☐ Weight Change	☐ Breathing Problems	☐ Fever/Chills	☐ Heart Problems
☐ Stomach Problems	☐ Joint pain/ Swelling	☐ Morning Stiffness	☐ Weakness	☐ Skin Problems
☐ Bowel/Bladder Changes	☐ Night Pain	☐ Depression/Anxiety	☐ Numbness	☐ Tingling
☐ Shortness of Breath	☐ Vision Change	☐ Sleep Problems	☐ Headaches	☐ Chest Pain
☐ Rash	☐ Other_____			

Have you had any of the following tests or treatments for your current problem?

	NO	YES	Date(s)		NO	YES	Date(s)
X-Rays	☐	☐	_____	EMG (Nerve Test)	☐	☐	_____
CT Scan	☐	☐	_____	Bone Scan	☐	☐	_____
MRI Scan	☐	☐	_____	Injection	☐	☐	_____
Surgery	☐	☐	_____	Physical Therapy	☐	☐	_____
Medications	☐	☐	_____				

If yes, list names of medications for current problem _____

Medical History		
Past Medical Problems:	Past Surgeries	Dates
Name All Current Medications:	List Any Medication Allergies	

Do you have allergies to any of the following?

☐ Shellfish ☐ Iodine ☐ Contrast/ IV Dye ☐ Latex

Does anyone in your family have any of the following medical problems?

Family Member	Alive	Arthritis	Cancer	Heart Disease	Diabetes	Other
	☐ Y ☐ N					
	☐ Y ☐ N					
	☐ Y ☐ N					

Have you received the Pnemonia Vaccination? ☐ No ☐ Yes Date:_____/____/_____

Have you received the Influenza Immunization? ☐ No ☐ Yes Date:_____/____/_____

Social History

Do you smoke? ☐ Yes How many packs per day? ___ ☐ Not currently, but I used to. Quit date: ___/___/____ ☐ No	**Do you consume alcohol** ☐ Yes How many drinks in one week? ___ ☐ No
Current Residence: ☐ House ☐ Apartment ☐ Other Stairs? ☐ Yes ☐ No Elevator? ☐ Yes ☐ No	**Employment Status:** ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed ☐ Disability ☐ Worker's Compensation If applicable, what is your occupation? _____

Urinary Symptoms

Do you experience any of the following?

Urinary incontinence (leakage of urine or urinary accidents) ☐ NO ☐ YES

If YES: (check all that apply)

☐ With: coughing/sneezing/laughing/exercise ☐ Occurs suddenly without warning

☐ Started during pregnancy ☐ Started after delivery of my baby

☐ Occurs because I cannot walk well enough to get to the bathroom on time

Feeling like you suddenly need to urinate ☐ NO ☐ YES

Feeling you urinate too frequently ☐ NO ☐ YES: How many times per day? ___

Feeling like you cannot empty your bladder fully ☐ NO ☐ YES

Cannot start your urine stream ☐ NO ☐ YES

Wake up to urinate more than 2x per night ☐ NO ☐ YES: How many times per night? ___

Pain with urination ☐ NO ☐ YES

Gastrointestinal

Do you experience any of the following?

Fecal incontinence (leakage of feces or bowel accidents)	☐ NO	☐ YES
Difficulty holding bowel movements or gas	☐ NO	☐ YES
Constipation	☐ NO	☐ YES: How many bowel movements per week?___
Do you have increased pain with bowel movements?	☐ NO	☐ YES
Does your pain improve after completing a bowel movement?	☐ NO	☐ YES

Sexual History

Are you currently sexually active?	☐ NO	☐ YES
Do you experience pain with sexual intercourse?	☐ NO	☐ YES

If YES: (check all that apply)

☐ With initial penetration ☐ Deep pain during sex
☐ With orgasms ☐ Because of body/leg positioning

History of sexually transmitted disease? ☐ NO ☐ YES

History of sexual problems? (i.e. erectile dysfunction, inability to have an orgasm) ☐ NO ☐ YES

Additional Medical History

Do you have a history of?

Depression ☐ NO ☐ YES

Anxiety ☐ NO ☐ YES

If YES: Are you treated with medications?
☐ Currently ☐ In the past ☐Never

Are you treated with counseling?
☐ Currently ☐ In the past ☐ Never

Do you have trouble sleeping? ☐ NO ☐ YES

If YES: (check all that apply)
☐ Difficulty falling asleep ☐ Difficulty staying asleep
☐ Because of pain ☐ Because of racing thoughts, worry, or other

Have you ever:

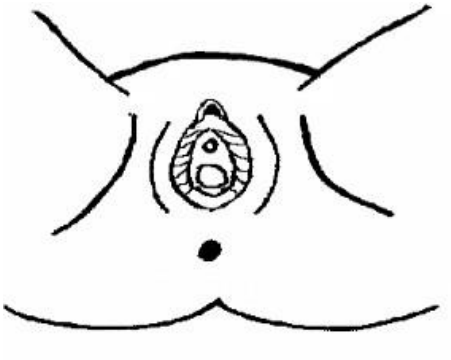
Been abused?	☐ NO	☐ YES
Had an eating disorder?	☐ NO	☐ YES
Felt unsafe at home or scared of your spouse/partner others?	☐ NO	☐ YES

FOR WOMEN ONLY (MEN PLEASE SKIP THE REMAINING QUESTIONS)

Vulvar / Perineal Pain

(Pain outside and around the vagina and anus)

If you have vulvar pain, shade in the painful areas on the diagram:



Information about Your Pain

What typed of treatments / providers have you tried in the past for your pain? (check all that apply)

☐ Acupuncture	☐ Family Practitioner	☐ Nutrition/Diet
☐ Anesthesiologist	☐ Herbal Medicine	☐ Physical Therapy
☐ Anti-seizure medications	☐ Homeopathic Medicine	☐ Psychotherapy
☐ Antidepressants	☐ Lupron, Synarel, Zoladex	☐ Psychiatrist
☐ Biofeedback	☐ Massage	☐ Rheumatologist
☐ Botox injection	☐ Meditation	☐ Skin Magnets
☐ Contraceptive	☐ Narcotics	☐ Surgery
☐ Danazol (Danocrine)	☐ Naturopathic Medication	☐ TENS unit
☐ Depo-provera	☐ Nerve blocks	☐ Trigger point
☐ Gastroenterologist	☐ Neurosurgeon	☐ Urologist
☐ Gynecologist	☐ Nonprescription medicine	

☐ Other:_____

Obstetrical History

When was your last menstrual period?_____/_____/_____

Are you pregnant? ☐ NO ☐ YES; # of weeks___

Number of pregnancies? _____

Number of children? _____

Ages of your children? _____

Are you currently breastfeeding? ☐ NO ☐ YES

Did you have back pain during your pregnancy? ☐ NO ☐ YES

How long was your last labor?_____

How long was your pushing phase? _____

What type of delivery/deliveries? (check all that apply)

☐ Vaginal ☐ C-section ☐ Vacuum ☐ Forceps

Have you had an episiotomy or tearing of vagina or rectum? ☐ NO ☐ YES

Any complications during pregnancy? (check all that apply)

☐ Hypertension ☐ Bleeding ☐ Contractions ☐ Diabetes

☐ Back Pain ☐ Pelvic Pain ☐ Bed Rest ☐ Other_____