Weill Cornell Medicine
Rehabilitation Medicine

Welcome!

Please indicate the physician you are seeing today:

- ☐ Nasser Ayyad, DO
- ☐ Jaclyn Bonder, MD
- ☐ Michelle Chi, MD
- ☐ Kuntal Chowdhary, MD
- ☐ Prabhav Deo, MD
- ☐ Kristen de Vries, DO
- ☐ Victoria Harrison, MD
- ☐ Stanley Guillaume, MD
- ☐ Dara Jones, MD
- ☐ Chi Chang David Lin, MD
- ☐ Leroy Lindsay, MD
- ☐ Ben Shin, MD
- ☐ Joan Stilling, 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

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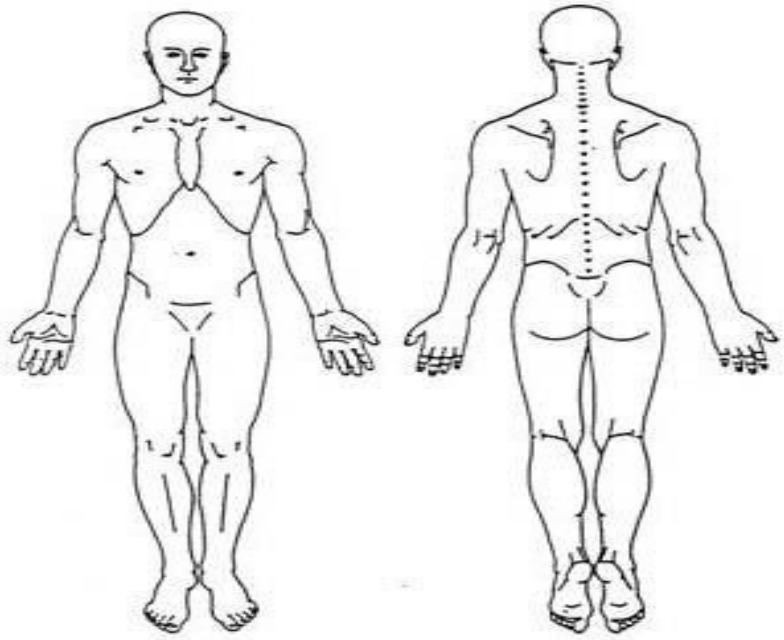
☐ SCQ

BP____ Puke____
HT____WT_____

Patient Name:	Patient Date of Birth:
Where is the location of the primary pain (reason you are here today)?	Referring Provider:
Did you sustain your injury on the job or during a motor vehicle accident? ☐NO ☐YES	
How long have you been experiencing the symptoms that you are seeking treatment for today?	
How did the symptoms begin?	

On the diagram below, please mark where you feel pain.



Pain Intensity

Please rate your **pain intensity, for your primary pain,** by marking the number that best describes your pain. 0 = no pain, 10 = most severe pain

	0	1	2	3	4	5	6	7	8	9	10
Worst pain this past week	○	○	○	○	○	○	○	○	○	○	○
Least amount pain this past week	○	○	○	○	○	○	○	○	○	○	○
Average pain this past week	○	○	○	○	○	○	○	○	○	○	○
Current pain severity	○	○	○	○	○	○	○	○	○	○	○

1. **What does the pain feel like?** _____
2. **What makes the pain better?** _____
3. **What makes the pain worse?** _____
4. **Since the pain began is it getting better, worse, or staying the same?** _____

Pain Interference

Please mark the number that describes how much, during the past week, your pain has interfered with each of the following activities.
0 = does not interfere with activity, 10 = completely interferes with activity.

	0	1	2	3	4	5	6	7	8	9	10
General activity	○	○	○	○	○	○	○	○	○	○	○
Mood	○	○	○	○	○	○	○	○	○	○	○
Walking ability	○	○	○	○	○	○	○	○	○	○	○
Normal work	○	○	○	○	○	○	○	○	○	○	○
Relationships with other people	○	○	○	○	○	○	○	○	○	○	○
Sleep	○	○	○	○	○	○	○	○	○	○	○
Enjoyment of life	○	○	○	○	○	○	○	○	○	○	○

Have you ever had pain in this area prior to this episode? If yes, when _____

Have you had any recent falls due to this pain? _____

Do you require an assistive device (such as a cane, walker, or a brace? _____

Please indicate if you have been evaluated by any other specialists for your current issue (check all that apply):

☐ Pain Management ☐ Physical Medicine and Rehab ☐ Other
☐ Orthopedic surgery ☐ Neurosurgery
☐ Neurology ☐ Rheumatology

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?

	NO	YES	Date(s)		NO	YES	Date(s)
X-Rays	☐	☐	_____	EMG (Nerve Test)	☐	☐	_____
CT scan	☐	☐	_____	Bone Scan	☐	☐	_____
MRI Scan	☐	☐	_____				

What treatments have you had for your current problem?

☐ Physical therapy ☐ Bracing ☐ Surgery ☐ Injection ☐ Acupuncture ☐ Chiropractor
☐Other_____