



DR. MARIA A. PERRI

## Patient Information

Please print

# \_\_\_\_\_ Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F Social Security #: \_\_\_\_\_

Employer name: \_\_\_\_\_ Occupation: \_\_\_\_\_

(if a minor, head of household employer)

Employer address: \_\_\_\_\_ Phone: \_\_\_\_\_

If married, spouse's name: \_\_\_\_\_

Spouse's employer: \_\_\_\_\_ Phone: \_\_\_\_\_

### ***Type of Patient and/or payment method (circle one)***

NF Auto Accident (No-Fault)

PI Personal Injury Case

WC Employment Injury (Workers Compensation)

MM Major Medical Insurance

C Cash payment

MR Medicare

Referred to this office by: \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize the office of Dr. Maria Perri to release information concerning my examination and/or treatment. I authorize payment directly to this office for professional services, and I understand that I will be directly responsible for any unpaid balance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Your health history

Select one answer in each of the columns below:

## Occupation

- Professional/Technical
- Tradesman
- Clerical
- Homemaker
- Production
- Service/Retail
- Other

## Marital Status

- Married
- Widowed
- Separated
- Divorced
- Never married

## Education Level

- Less than 12 years
- High School
- 1-4 years of college
- Beyond 4 years of college
- Professional school

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## Do you NOW have any of the following conditions? (mark if YES)

- |   |  |
|---|--|
| <input type="checkbox"/> Congestive heart failure                                       | <input type="checkbox"/> Sciatica or chronic back problem      |
| <input type="checkbox"/> Chronic lung disease (including bronchitis or emphysema)       | <input type="checkbox"/> Hypertension or high blood pressure   |
| <input type="checkbox"/> Blindness or trouble seeing, even when wearing glasses         | <input type="checkbox"/> Angina                                |
| <input type="checkbox"/> Deafness or trouble hearing                                    | <input type="checkbox"/> Heart attack or myocardial infarction |
| <input type="checkbox"/> Sugar diabetes (diabetes mellitus) Type 1                      | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Sugar diabetes (diabetes mellitus) Type 2 adult onset?         | <input type="checkbox"/> Kidney disease                        |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Cancer                                |
| <input type="checkbox"/> Ulcer or gastrointestinal bleeding (not counting hemorrhoids)? | <input type="checkbox"/> Depression                            |
| <input type="checkbox"/> Arthritis or rheumatism  | <input type="checkbox"/> Other                                 |

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Do not smoke or

If you smoke cigarettes, how many do you smoke in an average day?

- Less than 1/2 pack     1/2 pack—1 pack     1—2 packs     over 2 packs

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Do not drink or

if you drink alcohol, about how many drinks in an average day?

- Less than 1 drink     no more than 1     1 or 2 drinks     3—5 drinks     6—8 drinks     more than 8 drinks

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Are you taking any medications?  no     yes    If yes, please specify:

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If female, are you pregnant? \_\_\_\_\_

Please list any operations, bad falls, broken bones, or injuries from childhood to present:

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## Check any symptoms you have or have had in the past six months:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Mid back pain       | <input type="checkbox"/> Neck pain           | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Shoulder pain     | <input type="checkbox"/> Hip pain            | <input type="checkbox"/> Arm pain            | <input type="checkbox"/> Leg pain        |
| <input type="checkbox"/> Hand numbness     | <input type="checkbox"/> Foot numbness       | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Dizziness       |
| <input type="checkbox"/> Sinus problem     | <input type="checkbox"/> Knee numbness       | <input type="checkbox"/> Nervousness/tension | <input type="checkbox"/> Allergies       |
| <input type="checkbox"/> General stiffness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anxiety/stress      | <input type="checkbox"/> Stomach problem |
| <input type="checkbox"/> Clicking jaw      | Other: _____                                 |  |  |
-

# Your present complaint

How would you describe your chief complaint at this time? \_\_\_\_\_

\_\_\_\_\_

When did it start? Date \_\_\_\_\_

(include at least month and year; day if known)

What is your history with this injury?  Sudden trauma  Reoccurrence  Repetitive trauma

What makes the pain worse? \_\_\_\_\_

\_\_\_\_\_

What makes the pain better? \_\_\_\_\_

\_\_\_\_\_

How would you describe the pain? \_\_\_\_\_

\_\_\_\_\_

Where is the pain located? \_\_\_\_\_

\_\_\_\_\_

At what time of day or week is your pain worst? \_\_\_\_\_

\_\_\_\_\_

The pain is: The pain is  Constant - or -  Intermittent and it usually lasts for  
\_\_\_\_\_ minute(s) \_\_\_\_\_ hour(s) \_\_\_\_\_ day(s) \_\_\_\_\_ week(s)

## ***How long have you been having pain?***

- 1 week or less
- 1-6 weeks
- > 6 weeks, but < 3 months
- 3 months—1 year
- Over 1 year

## ***How many times have you had this problem in the past?***

- Never
- 1-3 episodes
- 4 or more episodes

## ***When did you first have these or similar symptoms?***

- Never
- < 6 months ago
- 6 months—1 year ago
- More than 1 year ago

## ***Motor Vehicle Accident***

Is your pain the result of a motor vehicle accident?

yes  no

### Location of impact

- Rear end
- Frontal
- Side
- Both front and rear
- Both front and side
- Both side and rear

## ***Job Injury***

yes

- Is your pain the result of a work related injury?
- Have you been disabled from working because of pain during the past year?
- Have you filed a workman's compensation claim?

Disabled from \_\_\_\_\_  
To \_\_\_\_\_

## ***Personal Injury***

yes

- Is your pain the result of a personal injury outside of work or a motor vehicle accident?
- Have you filed a legal suit?

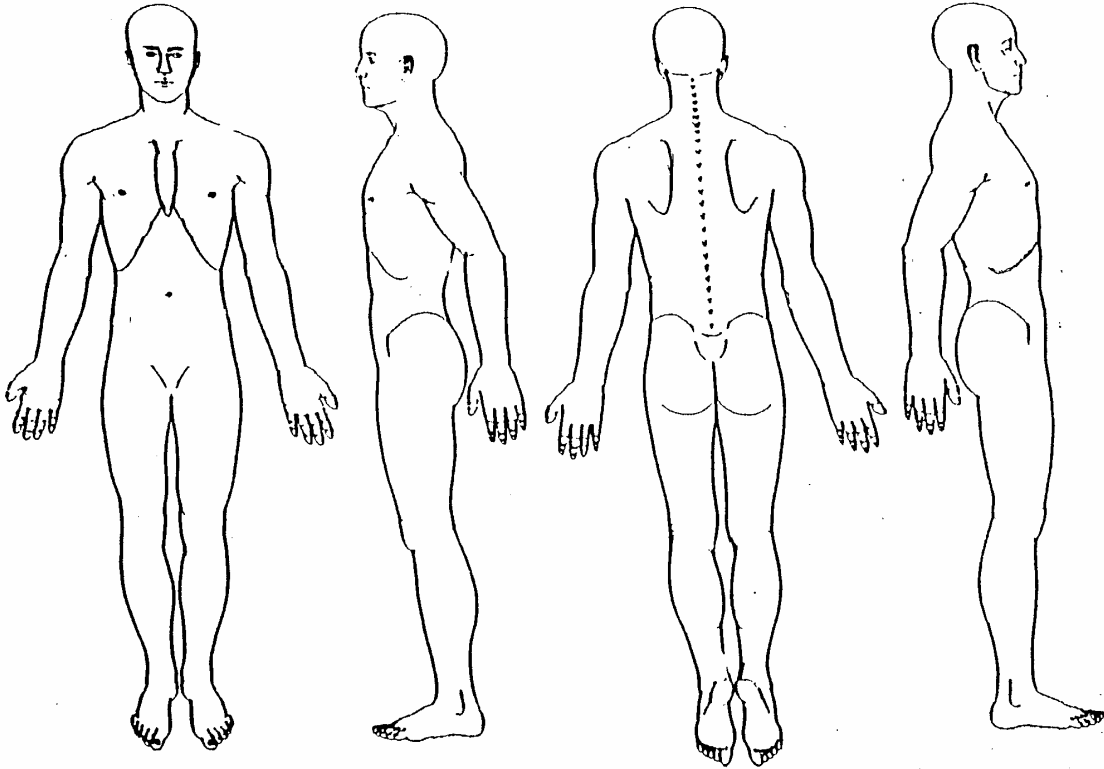
# Pain Drawing

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Please use the following descriptive symbols on the body outlines below to describe the location of your problem. In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
AAAAA	=====	0000000	.....	//////////	XXXXXX



**Please check the box at the level that most accurately represents your pain:**

	0	1	2	3	4	5	6	7	8	9	10	
Right now: No pain												Unbearable
Average pain: No pain												Unbearable
At best/worst: No pain												Unbearable

# Neck Index

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

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# Back Index

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

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