Kimelman Medical Group

NAME_____ **DATE**_____**EMAIL**_____

Social Security Number _____

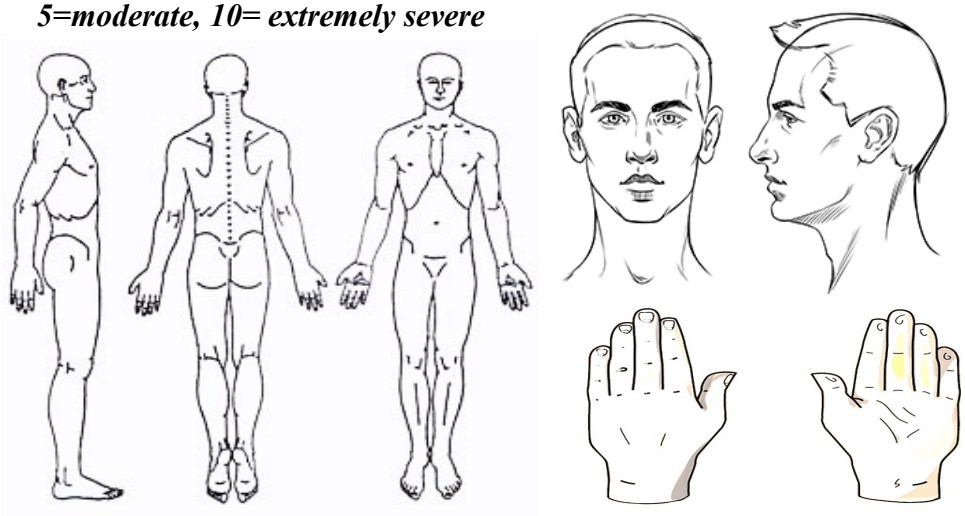
Thorough, accurate, legible responses support the doctor's ability to provide a comprehensive evaluation of your injury.

- ***Please take your time to complete this questionnaire. This may take a while.***
- ***Email Questionnaire to ma@kimelmanmd.com***
- ***Mail Questionnaire to 4 Florida Street.***
  - ***If mailed, please send 4 business days before scheduled appointment***

Please list ***all*** your current medications.

Medication Name	Milligram Dosage	How Often	Daily Dosage	Last date Rx was consumed	Refill request today?	Last pharmacy fill date
Example: Gabapentin	100 mg	2 at night	200 mg	11/19/19	Yes	1/01/2018

Rate painful body parts, 1-10, on picture and chart. ***1 = mild, 5=moderate, 10= extremely severe***



Pain: with treatment	Pain: with out treatment	Body Part

If you have had a procedure done in our office, please answer the following questions

Procedure Date: _____*Side Injected:* **Left** or **Right** *Body part injected:* _____

Please ***circle*** *the type of procedure you had:*

Trigger Point Injection • Steroid Injection • Hyaluronic Acid Injection • PRP Injection

*Please describe pain level, **1-10 before and after injections**:*

Pain level **before** injections: _____ Pain level **after** injections: _____

Activities of Daily Living

Please indicate your ability to perform the following activities with treatment vs. without treatment: *** **NUMBERS ONLY*****

Activity	With Treatment *(medications and injections)*	Without Treatment	Unit per event
Example: Walk	***30***	***5***	Blocks, ***Minutes,*** Steps?
Remain out of bed			Hours
Walk			Blocks, Minutes, Steps?
Sit			minutes
Stand			minutes
Shower			minutes
Shop			minutes
Exercise			minutes
Carry a gallon			minutes

Epworth sleepiness risks

Please circle risk of dozing during:

Dozing with Sedentary Activates	Absent	Mild	Moderate	Severe
Reading quietly	0	1	2	3
Watching TV quietly	0	1	2	3
Sitting quietly	0	1	2	3
Lying down quietly	0	1	2	3
Chatting quietly	0	1	2	3
Digesting meal	0	1	2	3
Traveling quietly	0	1	2	3
Sitting quietly in vehicle	0	1	2	3
Total of above scores				

Sleep Characteristics

Sleep Criteria	With treatment				Without treatment				Measurements
Sleep duration									hours
Total painful interruptions									episodes
Minutes to falling asleep									minutes
Minutes to getting out of bed									minutes
Early morning fatigue	0	1	2	3	0	1	2	3	Fatigue
Late afternoon fatigue	0	1	2	3	0	1	2	3	Fatigue

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, I have been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about myself, that I have failed	0	1	2	3
7. Trouble concentrating, such as to read a newspaper or watch T.V.	0	1	2	3
8. Moving or speaking so slowly or the opposite — being so fidgety or restless	0	1	2	3
9. Thinking that I would be better off dead or hurting myself	0	1	2	3
Total of above scores				

Disability status

Circle current disability or working status

Working	**Permanent and Stationary (PS)**	**Temporary Total Disability (TTD)** **66% of income**	**EDD** **55% of income**	**Permanent Disability (PD)** **Max: $290 per week**	**SSDI**	**None**

If unsure, what was amount of last disability check? _____

When did payments start? _____

Review of Systems

Please CIRCLE any symptoms you are experiencing:

General	Fatigue, Weight loss, Weight gain, Insomnia, Fever, Decreased appetite
Head & Neck	Headache, head injury, neck pain, head pain, stiffness, soreness, lumps or bumps.
EENT	Decreased hearing, Ringing in ears, Earaches, Drainage, Vision Loss/Changes, Eye redness, Blurry or double vision, Teeth Grinding
Respiratory	Cough, Sputum, Shortness of Breath, Painful Breathing, Wheezing
Cardiovascular	Chest Pain, Tightness, Palpitations, Swelling, Hypertension, Difficulty breathing, Feet Swelling
Gastrointestinal	Heartburn, Nausea, Diarrhea, Vomiting, Constipation, Rectal bleeding, Yellow eyes or skin
Genitourinary	Frequency, Urgency, Burning or pain, Blood in urine, Incontinence
Skin	Rashes, Lumps, Itching, Dryness, Change in color, Breast Cancer
Neurological	Dizziness, Fainting, Seizures, Weakness, Numbness, Tingling, Tremor
Hematologic/ Lymphatic	Frequent infections, Non-healing wounds, Excessive bleeding, Excessive clotting
Immunologic	Allergies (to medicines, food, clothing), Hay fever
Psychiatric	Nervousness, Stress, Depression, Memory loss, Anxiety
Endocrine	Thyroid disease, Diabetes