Weill Cornell Medicine
Rehabilitation Medicine

Welcome!

Please indicate the physician you are seeing today:

Jaclyn Bonder, MD	Michael O'Dell, MD
Alfred Gellhorn, MD	Jesuel Padro-Guzman, MD
Victoria Harrison, MD	Ethan Rand, MD
Chi Chang David Lin, MD	Jaspal Ricky Singh, MD
Leroy Lindsay, MD	Michael Sein, 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

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

Weill Cornell Medicine
Rehabilitation Medicine

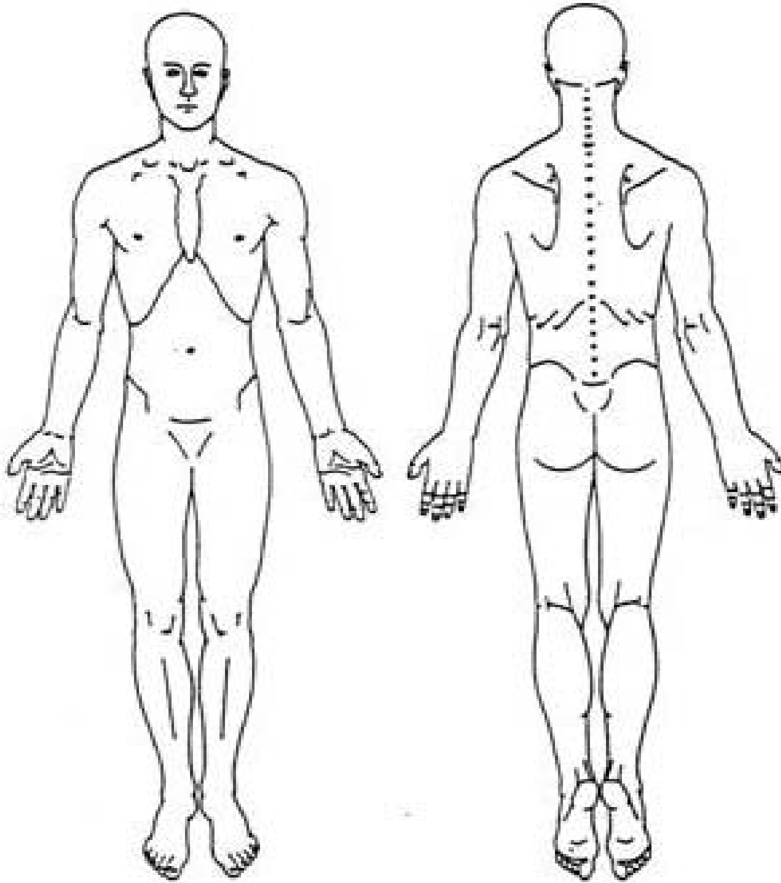
SCQ

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
Radiating	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 use to. Quit date: _____/_____/_____ No	**Do you consume alcohol?** No Yes How many drinks in one week? _______
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? ______________________________