**NAME:** _____ **DATE:** _____ **RECHECK CHECK-IN**

**INFORMATION UPDATE – Please Print Legibly**

| PATIENT NAME | TODAY'S DATE |
|---|---|
| | |

**MAILING ADDRESS**

| CITY | STATE | ZIP | DATE OF BITH |
|---|---|---|---|
| | Texas | | |

| HOME PHONE | CELL PHONE | WORK PHONE |
|---|---|---|
| | | |

**WHICH WORKING TELEPHONE NUMBER ABOVE CAN WE USE TO SEND YOU REMINDERS FOR UPCOMING APPOINTMENTS AFTER 5:00 PM?** ○ Home Phone ○ Cell Phone ○ Work Phone

**IN WHAT LANGUAGE WOULD YOU PREFER REMINDER CALLS:** ○ English ○ Spanish

**IF YOU DO NOT SPEAK ENGLISH, WE NEED A PHONE NUMBER THAT THE DOCTOR CAN CALL AFTER 5:00 PM AND BE ABLE TO SPEAK WITH SOMEONE WHO SPEAKS ENGLISH ABOUT YOUR HEALTH CARE.**

| NAME OF INDIVIDUAL SPEAKING ENGLISH | PHONE NUMBER |
|---|---|
| | |

**THE FEDERAL GOVERNMENT REQUIRES US TO SEND PATIENTS ELECTRONIC CLINICAL SUMMARIES WITHIN 4 DAYS OF THEIR APPOINTMENT. IN ORDER TO MEET THIS REQUIREMENT, WE NEED AN EMAIL ADDRESS. PLEASE PROVIDE US WITH AN EMAIL ADDRESS TO MEET THIS REQUIREMENT. WE WILL NEVER SELL YOUR INFORMATION TO A THIRD PARTY.**

**@**

**Is any of the information different from your previous appointment?** ○ YES ○ NO

## RECENT FALLS

○ NO ○ YES Have you experienced any falls since your last doctor's appointment?

## JOINT PAIN TODAY

Please mark any joints that are **CURRENTLY** giving you problems **TODAY**. Answer all questions for that particular joint. If the joint is not bothering you TODAY, skip to the next joint.

**JAW**

☐ Left Jaw ☐ Right Jaw ☐ Both Jaws

Pain Scale:
- ☐ 1
- ☐ 2 – Hurts Little Bit
- ☐ 3
- ☐ 4 – Hurts Little More
- ☐ 5
- ☐ 6 – Hurts Even More
- ☐ 7
- ☐ 8 – Hurts Whole Lot
- ☐ 9
- ☐ 10 – Worst Pain Imaginable

Pain Type: ☐ Achy ☐ Burning ☐ Dull ☐ Grinding ☐ Hot ☐ Numbness ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Swollen ☐ Tender ☐ Tingling

**NAME:** _____ **DATE:** _____ **RECHECK CHECK-IN**

**BACK**

☐ Neck/Upper Back ☐ Middle Back ☐ Lower Back

Pain Scale:
☐ 1
☐ 2 – Hurts Little Bit
☐ 3
☐ 4 – Hurts Little More
☐ 5
☐ 6 – Hurts Even More
☐ 7
☐ 8 – Hurts Whole Lot
☐ 9
☐ 10 – Worst Pain Imaginable

Pain Type:
☐ Achy ☐ Burning ☐ Dull ☐ Grinding ☐ Hot ☐ Numbness
☐ Shooting ☐ Stabbing ☐ Stinging ☐ Swollen ☐ Tender ☐ Tingling

**SHOULDER**

☐ Left Shoulder ☐ Right Shoulder ☐ Both Shoulders

Pain Scale:
☐ 1
☐ 2 – Hurts Little Bit
☐ 3
☐ 4 – Hurts Little More
☐ 5
☐ 6 – Hurts Even More
☐ 7
☐ 8 – Hurts Whole Lot
☐ 9
☐ 10 – Worst Pain Imaginable

Pain Type:
☐ Achy ☐ Burning ☐ Dull ☐ Grinding ☐ Hot ☐ Numbness
☐ Shooting ☐ Stabbing ☐ Stinging ☐ Swollen ☐ Tender ☐ Tingling

**ELBOW**

☐ Left Elbow ☐ Right Elbow ☐ Both Elbows

Pain Scale:
☐ 1
☐ 2 – Hurts Little Bit
☐ 3
☐ 4 – Hurts Little More
☐ 5
☐ 6 – Hurts Even More
☐ 7
☐ 8 – Hurts Whole Lot
☐ 9
☐ 10 – Worst Pain Imaginable

Pain Type:
☐ Achy ☐ Burning ☐ Dull ☐ Grinding ☐ Hot ☐ Numbness
☐ Shooting ☐ Stabbing ☐ Stinging ☐ Swollen ☐ Tender ☐ Tingling

**WRIST/HANDS**

☐ Left Wrist/Hand ☐ Right Wrist/Hand ☐ Both Wrists/Hands

Pain Scale:
☐ 1
☐ 2 – Hurts Little Bit
☐ 3
☐ 4 – Hurts Little More
☐ 5
☐ 6 – Hurts Even More
☐ 7
☐ 8 – Hurts Whole Lot
☐ 9
☐ 10 – Worst Pain Imaginable

Pain Type:
☐ Achy ☐ Burning ☐ Dull ☐ Grinding ☐ Hot ☐ Numbness
☐ Shooting ☐ Stabbing ☐ Stinging ☐ Swollen ☐ Tender ☐ Tingling

**NAME:** _____ **DATE:** _____ **RECHECK CHECK-IN**

**HIP/PELVIS**

☐ Left Hip/Pelvis ☐ Right Hip/Pelvis ☐ Both Hips/Pelvis

Pain Scale:
☐ 1
☐ 2 – Hurts Little Bit
☐ 3
☐ 4 – Hurts Little More
☐ 5
☐ 6 – Hurts Even More
☐ 7
☐ 8 – Hurts Whole Lot
☐ 9
☐ 10 – Worst Pain Imaginable

Pain Type:
☐ Achy ☐ Burning ☐ Dull ☐ Grinding ☐ Hot ☐ Numbness
☐ Shooting ☐ Stabbing ☐ Stinging ☐ Swollen ☐ Tender ☐ Tingling

**KNEE**

☐ Left Knee ☐ Right Knee ☐ Both Knees

Pain Scale:
☐ 1
☐ 2 – Hurts Little Bit
☐ 3
☐ 4 – Hurts Little More
☐ 5
☐ 6 – Hurts Even More
☐ 7
☐ 8 – Hurts Whole Lot
☐ 9
☐ 10 – Worst Pain Imaginable

Pain Type:
☐ Achy ☐ Burning ☐ Dull ☐ Grinding ☐ Hot ☐ Numbness
☐ Shooting ☐ Stabbing ☐ Stinging ☐ Swollen ☐ Tender ☐ Tingling

**FEET/ANKLE**

☐ Left Foot/Ankle ☐ Right Foot/Ankle ☐ Both Feet/Ankles

Pain Scale:
☐ 1
☐ 2 – Hurts Little Bit
☐ 3
☐ 4 – Hurts Little More
☐ 5
☐ 6 – Hurts Even More
☐ 7
☐ 8 – Hurts Whole Lot
☐ 9
☐ 10 – Worst Pain Imaginable

Pain Type:
☐ Achy ☐ Burning ☐ Dull ☐ Grinding ☐ Hot ☐ Numbness
☐ Shooting ☐ Stabbing ☐ Stinging ☐ Swollen ☐ Tender ☐ Tingling

**NAME:** _____ **DATE:** _____ **RECHECK CHECK-IN**

**HEALTH ASSESSMENT QUESTIONNAIRE – DISABILITY INDEX**

| | Without ANY Difficulty | With SOME Difficulty | With MUCH Difficulty | UNABLE To Do | OFFICE USE ONLY |
|---|---|---|---|---|---|
| **Are you able to:** | **0** | **1** | **2** | **3** | |
| **DRESSING & GROOMING** | | | | | |
| **1.** Dress yourself, including tying shoelaces and doing buttons | ○ | ○ | ○ | ○ | |
| **2.** Shampoo your hair | ○ | ○ | ○ | ○ | |
| **ARISING** | | | | | + |
| **3.** Stand up from a straight chair? | ○ | ○ | ○ | ○ | |
| **4.** Get in and out of bed? | ○ | ○ | ○ | ○ | |
| **EATING** | | | | | + |
| **5.** Cut your own meat? | ○ | ○ | ○ | ○ | |
| **6.** Lift a full cup or glass to your mouth? | ○ | ○ | ○ | ○ | |
| **7.** Open a new milk carton? | ○ | ○ | ○ | ○ | |
| **WALKING** | | | | | + |
| **8.** Walk outdoors on flat ground? | ○ | ○ | ○ | ○ | |
| **9.** Climb up five (5) steps? | ○ | ○ | ○ | ○ | |
| **HYGIENE** | | | | | + |
| **10.** Wash and dry your body? | ○ | ○ | ○ | ○ | |
| **11.** Take a tub bath, if desired? | ○ | ○ | ○ | ○ | |
| **12.** Get on and off the toilet? | ○ | ○ | ○ | ○ | |
| **REACH** | | | | | + |
| **13.** Reach and get a 5-pound object from just above your head? | ○ | ○ | ○ | ○ | |
| **14.** Bend down and pick up clothing from the floor? | ○ | ○ | ○ | ○ | |
| **GRIP** | | | | | + |
| **15.** Open car doors? | ○ | ○ | ○ | ○ | |
| **16.** Open jars which have been previously opened? | ○ | ○ | ○ | ○ | |
| **17.** Turn faucets on and off? | ○ | ○ | ○ | ○ | |
| **ACTIVITIES** | | | | | + |
| **18.** Run errands and shop? | ○ | ○ | ○ | ○ | |
| **19.** Get in and out of a car? | ○ | ○ | ○ | ○ | |
| **20.** Do chores such as vacuuming or yard work? | ○ | ○ | ○ | ○ | |
| | | | | | = |

**Mark any AIDS or DEVICES that you usually use for any of these activities:**

- ☐ Bathtub Bar
- ☐ Bathtub Seat
- ☐ Built-Up/Special Utensils
- ☐ Cane
- ☐ Crutches
- ☐ Dressing Devices (button hook, zipper pull, long shoehorn, etc.)
- ☐ Jar Opener (for previously opened jars)
- ☐ Long-Handled Appliances for Reach
- ☐ Long-Handled Appliances in Bathroom
- ☐ Raised Toilet Seat
- ☐ Special/Built-Up Chair
- ☐ Walker
- ☐ Wheelchair

÷ **8** =

**YOUR HAQ SCORE →**

**NAME:** _____ **DATE:** _____ **RECHECK CHECK-IN**

**Mark any categories for which you usually need HELP FROM ANOTHER PERSON:**

☐ Arising ☐ Eating ☐ Hygiene ☐ Walking
☐ Dressing & Grooming ☐ Errands & Chores ☐ Reaching
☐ Gripping & Opening Things

We are also interested in learning whether or not you are affected by pain because of your illness.

**YOUR ACTIVITIES:** To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

○ Completely ○ Mostly ○ Moderately ○ A Little ○ Not At All

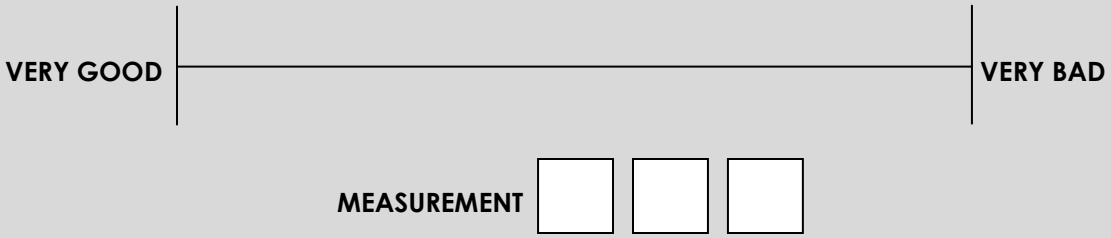
**YOUR PAIN:** How much pain have you had in the past week? Record the number below.
0 = No Pain to 100 = Severe Pain _____ _____ _____

**YOUR HEALTH:** Rate how well you are doing. Record the number below.
0 = Very Poor to 100 = Very Well _____ _____ _____

**← FOR OFFICE USE ONLY --- FOR OFFICE ONLY --- FOR OFFICE USE ONLY →**

**FOR PHYSICIAN ONLY** ****DO NOT COPY****

**PHYSICIAN'S GLOBAL ASSESSMENT:** Make an "|" on the line below to indicate the activity, independently of the patient's self assessment.



**NAME:** _____ **DATE:** _____ **RECHECK CHECK-IN**

**OVERALL**
- ☐ Change in Appetite
- ☐ Change in Weight
- ☐ Chills
- ☐ Edema
- ☐ Fatigue
- ☐ Fever
- ☐ Insomnia (difficulty sleeping)
- ☐ Night Sweats
- ☐ Weakness

Other:

**EYES**
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Feeling of Something in Eyes
- ☐ Loss of Vision

Other:

**EARS, NOSE, MOUTH, THROAT**
- ☐ Change in Appearance of Neck
- ☐ Difficulty with Balance
- ☐ Difficulty with Swallowing
- ☐ Dry Ears/Nose/Mouth/Throat
- ☐ Hearing Problems
- ☐ Injury to Head, Neck, Mouth, Throat
- ☐ Lumps or Swollen Glands
- ☐ Mouth Sores
- ☐ Neck Pain/Stiffness
- ☐ Sinus Problems

Other:

**CARDIOVASCULAR**
- ☐ Chest Pain
- ☐ Palpitations (heart fluttering)
- ☐ Shortness of Breath at Night
- ☐ Swollen Ankles/Legs

Other:

**RESPIRATORY**
- ☐ Coughing Up Blood
- ☐ Frequent Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma

Other:

**DIGESTIVE**
- ☐ Abdominal Pain
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Colon Screening (colonoscopy)
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Heartburn/GERD
- ☐ Indigestion
- ☐ Nausea/Vomiting

Other:

**GENITOURINARY**
- ☐ Blood in Urine
- ☐ Excessive Urination
- ☐ Painful Urination
- ☐ Trouble Urinating
- ☐ Vaginal Dryness

Other:

**MUSCULOSKELETAL**
- ☐ Back Pain
- ☐ Broken/Fractured Bone(s)
- ☐ Muscle Cramps/Aches
- ☐ Stiffness
- ☐ Swollen/Tender Joints

Other:

**SKIN**
- ☐ Acne
- ☐ Breast Discharge
- ☐ Breast Tenderness
- ☐ Change in Complexion
- ☐ Change in Perspiration (sweat)
- ☐ Change in Skin Texture
- ☐ Color Changes in Hands/Feet in Cold
- ☐ Hair Loss
- ☐ Lumps in Breast
- ☐ Rash ☐ Itching
- ☐ Sun Sensitivities

Other:

**NEUROLOGICAL**
- ☐ Change in Movement
- ☐ Dizziness
- ☐ Loss of Consciousness
- ☐ Memory Loss
- ☐ Numbness of Arms/Legs
- ☐ Poor Balance/Unsteady Walk
- ☐ Seizures
- ☐ Severe Headaches
- ☐ Tingling or Altered Sensations
- ☐ Tremors or Shaking

Other:

**PSYCHIATRIC**
- ☐ Confusion
- ☐ Previous Psychiatric Care
- ☐ Sad/Depressed
- ☐ Tense/Anxious
- ☐ Thoughts of Death

Other:

**HORMONAL**
- ☐ Change in Energy Level
- ☐ Change in Temperature Tolerance
- ☐ Frequent Thirst
- ☐ Frequent Urination ☐ at Night

Other:

**HEMATOLOGIC/LYMPHATIC**
- ☐ Easy Bruising
- ☐ Problems with Excessive Bleeding
- ☐ Swollen Glands

Other:

**ALLERGIC/IMMUNOLOGIC**
- ☐ Seasonal Allergies

Other:

## CURRENT HEALTH PROBLEMS

**Select any problems you are CURRENTLY experiencing**