Dr. Michael Koehler ■ 601 South Route 59 ■ Ingleside, IL 60041 ■ 847-587-8011

Patient Information Sheet

Please print.

Date: _____

Patient Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail address:

_____

Home Phone: _____ (Cell) _____ (Work) _____

Birthdate: _____ Social Security Number _____ - _____ - _____

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Partnered ☐ Single ☐ Minor

Spouse/Partner Name: _____ Phone Number: _____

Emergency contact if different than spouse:

_____

Employment Status: ☐ Retired ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student

Occupation: _____

Employer: _____ Employer's Phone: _____

Employer's Address/town:

_____

How did you hear about us? _____

What is the primary reason for you visit today? _____

When did your symptoms begin? _____

Is your injury:

Work related? YES NO

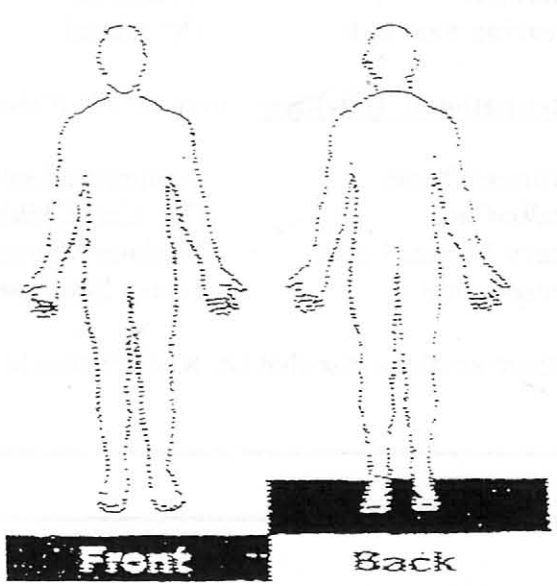
Vehicle Accident related? YES NO

How often do you experience your symptoms (***circle one***)?

Constantly Occasionally

Frequently Intermittently

Mark ***all areas*** where you are experiencing pain with an X:



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Please list any doctors you have seen thus far for your symptoms: _____

_____

What have you done to try to alleviate your symptoms: _____

_____

Medical History: *Please circle all medical conditions and surgeries that apply*

Arthritis	Diabetes	Pacemaker	Lung Disease
High blood pressure	Heart Disease	Stroke	High Cholesterol
Psychiatric Disorder	Cancer	Skin Disease	Other: _____

Surgeries:

Appendectomy	Carpal Tunnel	Hysterectomy	
Joint Replacement	Prostrate	Gall Bladder	
Brain	Shoulder	Knee	
Heart	Gastrointestinal	Hernia	Other: _____

Allergies:

_____

Social History: *Circle one*

Caffeine use:	Occasional	Often	Never
Tobacco use:	Occasional	Often	Never
Alcohol use:	Occasional	Often	Never
Exercise:	Occasional	Often	Never
Wearing Seat Belt:	Occasional	Often	Never

Occupational Activities: *Circle the **ONE** that most closely applies to your work situation*

Business Owner	Administration/Clerical	Executive/Legal	Computer/Data Entry
Health Care	Day Care/Childcare	Food Service	Housekeeper
Heavy Manual Labor	Medium Manual Labor	Light Manual Labor	
Construction	Heavy Equipment	Manufacturing	

Is there anything else that Dr. Koehler should be aware of regarding your health?

_____

_____

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Name: _____ Date: _____

Medicare Pain and Functional Outcome Questionnaire (*all diagnoses*)

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage everyday life. Please answer by checking **ONE BOX IN EACH SECTION** for the statement which best applies to you. We realize that you may consider that two or more statements apply, but please just choose **ONE** answer that **MOST CLEARLY DESCRIBES** your problem. Thank you!

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable pain at the moment

Section 2: Personal care e.g. washing/dressing

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

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently positioned e.g. on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking

- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than 100 feet
- ☐ I can only walk using a cane, walker or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting for more than 1 hour
- ☐ Pain prevents me from sitting for more than 30 minutes
- ☐ Pain prevents me form sitting for more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain, I have less than 6 hours sleep
- ☐ Because of pain, I have less than 4 hours sleep
- ☐ Because pain, I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Traveling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ My pain is bad but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to receive treatment

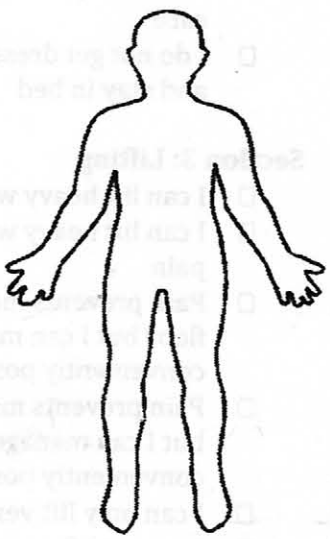
Section 9: Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life but limits more energetic interests e.g. sports
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents me from having a sex life at all

VISUAL ANALOG SCALE: ***Please*** mark all areas of pain on the diagram and circle the number below that best describes your pain ***right now***



Neck Pain

No Pain ——————————————— **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

Back Pain

No Pain ——————————————— **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

REV 3/16