3127 West International Speedway Boulevard
Daytona Beach, Florida 32124
Phone: (386) 258-9502
Fax: (386) 239-9781
Website: MedicalExerciseAssoc.com

DATE:___________________

NAME: (First/Middle/Last) ____ DATE OF BIRTH: _____________

SOCIAL SECURITY NUMBER: __________________________ EMAIL: _____________________________

HOME PHONE #: ______________________________ CELL PHONE #: _____________________________

ADDRESS: ____

OCCUPATION: ______________________________ EMPLOYER:
____

MARITAL STATUS: (Circle One) SINGLE MARRIED WIDOWED DIVORCED OTHER

NAME OF SPOUSE: ________________________________ SPOUSE'S DATE OF BIRTH: _____________

SPOUSE'S OCCUPATION: ____________________________ SPOUSE'S EMPLOYER: ________________

PRIMARY CARE PHYSICIAN: ______________________________ PHONE #: _______________________

HOW DID YOU HEAR ABOUT US? ____

DATE OF MOST RECENT VACCINE: INFLUENZA: ______________ PNEUMONIA: _______________

MEDICATIONS: ____
____
____

SUPPLEMENTS: ____

ALLERGIES: ____

I hereby authorize Medical Exercise Associates to release information acquired in the course of my examination or treatment to my representative or insurance company.

____
Patient Signature or Guardian (in case of minors)

I understand that I am personally responsible for all charges incurred at Medical Exercise Associates.

____
Patient Signature or Guardian (in case of minors)

MEDICAL EXERCISE ASSOCIATES
Michael N. Fulton M.D. • Brent N. Fulton M.D.

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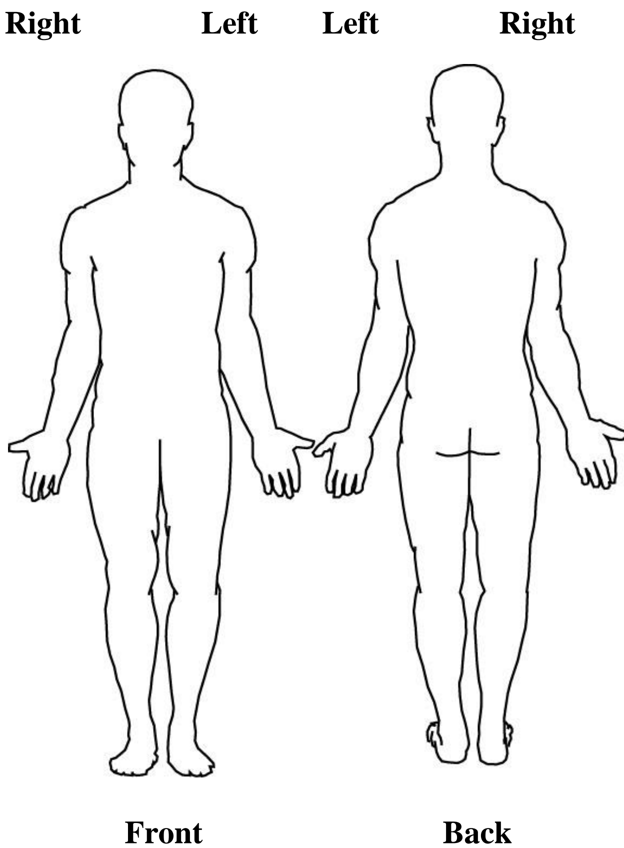
Pain Questionnaire

Name: ____ **Date:** ____________________

Using the appropriate symbols, please indicate on the figure the location and sensation of your pain today.

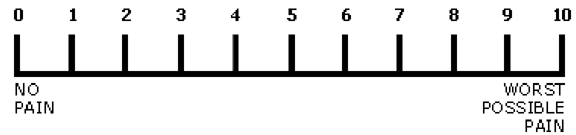
Right **Left** **Left** **Right**



Front **Back**

Numbness	Pins & Needles	Burning
- - - - - - - - -	o o o o o o o o o o	x x x x x x
Stabbing	Aching	Throbbing
/ / / / / / /	^ ^ ^ ^ ^ ^ ^ ^ ^	* * * * * *

What is your pain intensity on a zero to ten (0-10) scale?



Current level of pain? ______

Average daily level of pain? ______

Greatest daily level of pain? ______

Least daily level of pain? ______

State your problem:

____

____

____

____

Is your pain increased by any of the following?

- ❑ Standing ❑ Walking ❑ Bending
- ❑ Sitting ❑ Lying Down ❑ Twisting
- ❑ Lifting ❑ Exercise
- ❑ Other: ______________________________________

Is your pain relieved by any of the following?

- ❑ Sitting ❑ Lying Down ❑ Standing
- ❑ Medications ❑ Exercise ❑ Postural Change
- ❑ Other: ______________________________________

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Name:______________________________________ **Date:**_________________________

Systemic:

- ❑ Y Reported history of Cancer
- ❑ Y HIV Infection

Other:_________________________

HEENT :

- ❑ Y Glaucoma
- ❑ Y Esophageal Reflux
- ❑ Y Sleep Apnea
- ❑ Y Sinusitis

Other:_________________________

Pulmonary:

- ❑ Y Emphysema
- ❑ Y Chronic Bronchitis
- ❑ Y Asthma
- ❑ Y Pneumonia

Other:_________________________

Hematologic:

- ❑ Y Anemia
- ❑ Y Leukemia
- ❑ Y Bleeding Disorder

Other:_________________________

Integument:

- ❑ Y Cellulitis

Cardiovascular:

- ❑ Y Coronary Artery Disease
- ❑ Y Congestive Heart Failure
- ❑ Y Atrial Fibrillation
- ❑ Y Acute Myocardial Infarction
- ❑ Y Recent episode(s) of Angina
- ❑ Y Previous High Blood Pressure
- ❑ Y Valvar Heart Disease
- ❑ Y Venous Thrombosis

Other:_________________________

Genitourinary:

- ❑ Y Dialysis
- ❑ Y Prior Kidney Disease
- ❑ Y Urinary Tract Infection

Other:_________________________

Neurological:

- ❑ Y Epilepsies
- ❑ Y TIA
- ❑ Y Stroke Syndrome

Other:_________________________

Psychological:

- ❑ Y Depression

Other:_________________________

Gastrointestinal:

- ❑ Y Diverticulitis – Colon
- ❑ Y Pancreatitis
- ❑ Y Prior Liver Disease
- ❑ Y Gastric Ulcer
- ❑ Y Hepatitis
- ❑ Y Hiatal Hernia

Other:_________________________

Endocrine:

- ❑ Y Cholesterol problems
- ❑ Y Diabetes Mellitus
- ❑ Y Thyroid disorders

Other:_________________________

Musculoskeletal:

- ❑ Y Fracture
- ❑ Y Osteoporosis

Other:_________________________

Rheumatologic:

- ❑ Y Gout
- ❑ Y Rheumatoid Arthritis

Other:_________________________

Obstetric:

- ❑ Y Currently Pregnant

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Name:______________________________________ **Date:**_________________________

Systemic symptoms:

❑ Y ❑ N Weight change

❑ Y ❑ N Chills

❑ Y ❑ N Fever

❑ Y ❑ N Night sweats

❑ Y ❑ N Feeling tired or poorly

Other:________________________

HEENT symptoms:

❑ Y ❑ N Headache

❑ Y ❑ N Eyesight problems

❑ Y ❑ N Nosebleeds

Other:________________________

Neck Symptoms:

❑ Y ❑ N Neck pain

❑ Y ❑ N Neck Stiffness

❑ Y ❑ N Lump or swelling in neck

Other:________________________

Pulmonary symptoms:

❑ Y ❑ N Shortness of breath

❑ Y ❑ N Cough

❑ Y ❑ N Coughing up blood

❑ Y ❑ N Wheezing

Other:________________________

Cardiovascular symptoms:

❑ Y ❑ N Chest pain or discomfort

❑ Y ❑ N Fast heart rate

❑ Y ❑ N Palpitations

Other:________________________

Gastrointestional symptoms:

❑ Y ❑ N Difficulty swallowing

❑ Y ❑ N Heartburn

❑ Y ❑ N Nausea

❑ Y ❑ N Vomiting

❑ Y ❑ N Abdominal pain

❑ Y ❑ N Diarrhea

Other:________________________

Gentourinary symptoms:

❑ Y ❑ N Blood in urine

❑ Y ❑ N Painful urination

❑ Y ❑ N Increased urination

Other:________________________

Skin symptoms:

❑ Y ❑ N Pruritus

❑ Y ❑ N Skin lesions

❑ Y ❑ N Rashes

Other:________________________

Endrocrine symptoms:

❑ Y ❑ N Excessive sweating

❑ Y ❑ N Excessive thirst

Other:________________________

Hematological symptoms:

❑ Y ❑ N Easy bleeding

❑ Y ❑ N Easy bruising tendency

Other:________________________

Neurological symptoms:

❑ Y ❑ N Dizziness

❑ Y ❑ N Vertigo

❑ Y ❑ N Motor disturbance

❑ Y ❑ N Sensory disturbance

Other:________________________

Psychological symptoms:

❑ Y ❑ N Sleep disturbances

❑ Y ❑ N Anxiety

❑ Y ❑ N Depression

Other:________________________

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Name:_______________________________________ **Date:**_________________________

General Surgical History:

- ❑ Y Reaction to anesthetics
- ❑ Y History of eye surgery for cataracts
- ❑ Y Surgery of Pharanyx, Adenoids, and Tonsils
- ❑ Y Thyroidectomy
- ❑ Y Cardiac Pacemaker
- ❑ Y CABG
- ❑ Y Cholecystectomy
- ❑ Y Appendectomy
- ❑ Y Hernia Repair
- ❑ Y TURP
- ❑ Y Mastectomy
- ❑ Y Hysterectomy
- ❑ Y Cosmetic Surgery
- ❑ Y Hx of previous pregnancies, including cesarean

Other:_______________________________________

Surgical History for Lumbar & Thoracic Spine:

- ❑ Y Arthrodesis Lumbar
- ❑ Y Lumbar Vertebral Fusion
- ❑ Y Spinal Diskectomy
- ❑ Y Laminectomy Lumbar
- ❑ Y Arthrodesis Thoracic

Other:_______________________________________

Surgical History for Spine:

- ❑ Y Percutaneous Vertebral Augmentation Kyphoplasty
- ❑ Y Spinal Percutaneous Vertebroplasty Injection

Surgical History for Cervical Spine:

- ❑ Y Laminectomy Cervical
- ❑ Y Spinal Diskectomy Cervical
- ❑ Y Arthrodesis Cervical

Surgical History for Hip:

- ❑ Y Total Hip Replacement
- ❑ Y Revision of Total Hip Replacement
- ❑ Y Hip Arthroscopy with Debridement/Shaving of Articular Cartilage

Surgical History for Shoulder:

- ❑ Y Shoulder Arthroscopy
- ❑ Y With Space Decompression and Acromioplasty
- ❑ Y With Repair of SLAP Lesion
- ❑ Y With Rotator Cuff Repair
- ❑ Y With Biceps Tenodesis

Surgical History for Knee:

- ❑ Y Knee Arthroscopy
- ❑ Y With Debridement of Articular Cartilage
- ❑ Y With Medial Minescectomy
- ❑ Y With Lateral Minescectomy
- ❑ Y With Anterior Cruciate Ligament Repair
- ❑ Y With Posterior Cruciate Ligament Repair
- ❑ Y With Medial Collateral Ligament Repair
- ❑ Y With Lateral Collateral Ligament Repair
- ❑ Y Knee Replacement
- ❑ Y Revision of Knee Replacement
- ❑ Y Hemiarthroplasty of Knee

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Patient Health Questionnaire (PHQ-9)

Name: ____ **Date:** ______________________

Over the last two weeks, how often have you been bothered by any of the following problems? (Circle Answer)

	Not at All	Several Days	More than Half of 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 yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself	0	1	2	3
	Add columns			
	TOTAL:			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?	
	Not difficult at all ___________
	Somewhat difficult ___________
	Very difficult ___________
	Extremely difficult ___________

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Activities – Specific Balance Confidence (ABC) Scale

Name: ____ **Date:** _____________________

For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady by choosing one of the percentage points on the scale from 0% to 100%. If you do not currently do the activity in question, try to imagine how confident you would be if you had to perform the activity. If you normally use assistance, like a walker or cane, please rate your confidence while using these supports. Please ask the office staff if you have any questions.

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following scale:

0%	10	20	30	40	50	60	70	80	90	100%
Not Confident										Completely Confident

How confident are you that you will not lose your balance or become unsteady when you…

1. … walk around the house? ________%
2. … walk up or down stairs? ________%
3. … bend over and pick up a shoe from the front of a closet? ________%
4. … reach for a small can off of a shelf at eye level? ________%
5. … stand on tip toes and reach for something above your head? ________%
6. … stand on a chair and reach for something? ________%
7. … sweep the floor? ________%
8. … walk outside of the house to a car parked in the driveway? ________%
9. … get into or out of a car? ________%
10. … walk across a parking lot to a mall? ________%
11. … walk up or down a ramp? ________%
12. … walk in a crowded mall where people rapidly walk past you? ________%
13. … are bumped into by people as you walk through the mall? ________%
14. … step onto or off of an escalator while you are holding onto a railing? ________%
15. … step into or off of an escalator while holding onto parcels such that you cannot hold onto the railing? ________%