TRG FOLLOW-UP INTAKE FORM

Name: _____**DOB:** _____

Date: _____ CC **(Reason of visit):** _____

Who is with you today: _____

PCP/Other Consultants: _____

Any new concerns/complaints since last visit: **YES** **NO**

If so, please explain: _____

Do you have any pain today: **YES** **NO**

If so, on a scale of **0-10 (0 = no pain & 10 = extreme pain),** state your present pain level: _____

Location of greatest pain: _____

Describe your pain: aching, stiffness, throbbing, sharp, dull, radiating, chronic, constant, occasional, intermittent, other: _____

Aggravated by: _____

Reduced by: _____

Related symptoms: Tingling, numbness, weakness, other: _____

Any new diagnoses, conditions, surgeries, or procedures since last visit: **YES** **NO**

If so, please explain: _____

Do you need medication refills, medical equipment or forms to fill out: **YES** **NO**

If so, please explain: _____

Do you smoke: **YES** **NO**

Do you have diabetes: **YES** **NO**

If so, when was your last A1C test done: _____ **Results:** _____

Do you have a diagnosis of hypertension: **YES** **NO**

Have you been tested for colon cancer? **YES** **NO** **Date:** _____

What test was done (colonoscopy, FOBT, Flex Sig, CT of Colon, FIT-DNA): _____

My signature below certifies that the answers given, and information discussed are complete and true.

Patient/Guardian Signature: _____

Name: _____ Date of visit: _____

ROS:

Please CIRCLE any symptoms that you are experiencing today…

Constitutional: low energy/decreased appetite/ decreased activity/fever/chills/sweats/lethargy/ fatigue/malaise/weight loss/weight gain/sweats/other: or **normal**

Eyes: blurred vision/near sighted/far sighted/pain/blindness/glaucoma/cataracts to right/left or **normal**

ENT: nose bleeds/stuffiness/allergies/dizziness/difficulty swallowing/ear pain to right or left or **normal**

Resp: Shortness of breath/wheezing/cough/blood in cough/other or **normal**

Cardiovascular: Shortness of breath with exertion/chest pain/blood pressure issues/stroke/other or **normal**

Gastrointestinal: incontinence/bloating/nausea/vomiting/diarrhea/constipation or **normal**

Genitourinary: incontinence/urgency/frequency/pain with urination/slow stream or **normal**

Musculoskeletal: joint stiffness/swelling/activity limitation/back pain/neck pain/pain to joint or **normal**

Neurologic: muscle weakness/limb weakness/contracture/thinking problem/migraine/seizure/ dizziness/balance problem/memory loss/headaches or **normal**

Skin: rash/boils/dryness/bruising/redness/other: or **normal**

Endocrine: hot flashes/polyphasia/polydipsia/polyuria/heat intolerance/cold intolerance/ diabetes/thyroid disease/other: or **normal**

Hematology: history of blood clots/swollen glands/anemia/blood transfusions/other: or **normal**

Mood: anxiety/depression/frustration/poor concentration/poor attention/hallucinations/sleep disturbances/other: or **normal**

Patient Signature: _____

The Rehabilitation Group

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 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 other people could have noticed. Or the opposite — being so figety 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 of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

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 other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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