NORTHEAST REHABILITATION HOSPITAL NETWORK

INITIAL ASSESSMENT REV 11/15

Name:_____Date of Birth: _____Age: ____

Preferred Language: _____
Do you need an interpreter provided to you? ❒Yes ❒ No
Primary Care Physician: _____
Referring Physician: _____
Reason for Visit (where is your pain):
_____

Please rate your pain on a 0-10 scale with 0=no pain, 10=worst pain imaginable:
AM: _____/10 PM: _____/10 Night: _____/10

Pain History:

1. When did you first experience pain? _____
2. What started or caused the pain? _____
3. Is your pain constant or comes and goes? _____
4. Is the severity of your pain mild, moderate or severe? _____
5. Is your pain worsening or stable? _____
6. Does your pain radiate? Where? _____
7. Is your pain sharp, achy, shooting or burning? _____
8. Do you have any numbness or weakness? _____
9. What makes your pain worse? _____
10. What makes your pain better? _____

Prior pain therapy:
(What treatment of this condition have you had in the past?)

1. Medications:_____
   _____
   _____
2. Surgery:_____
3. Injections:_____
4. Physical Therapy: _____
5. Other:_____
6. Have you ever had any diagnostic imaging or testing (x-ray, MRI, EMG, etc)? _____
   If so, what type, where and when? _____

Surgical History: Please list all operations you have had: Date:

_____ _____
_____ _____
_____ _____
_____ _____

Medical History: Please list all active medical conditions

_____ _____
_____ _____
_____ _____

Are you **ALLERGIC** to any **medicines, latex, X-ray dye, or iodine**? ❒Yes ❒ No
If yes, please explain:

_____

Are you taking any "blood thinning" medications? ❒Yes ❒ No If yes, indicate below
❒ Plavix ❒Coumadin ❒Other: _____

Family History: ❒ Neuropathy ❒ Pain syndromes ❒ Depression
❒ Other _____

Social history:
Please circle: married/single/widowed
Occupation: _____ If not working please explain:

_____

Highest level of education completed: _____
Do you smoke cigarettes? ❒Yes ❒ No If so how many packs a day _____ # of years
Do you drink alcohol? ❒Yes ❒ No If so how much? _____
Do you have a history of substance abuse? ❒Yes ❒No Type: _____
Do you have a history of depression? ❒Yes ❒ No
Do you have a history of anxiety? ❒Yes ❒ No
Are you seeing a psychologist/psychiatrist? ❒Yes ❒No Name: _____

SOAPP Version 1.0-SF
Please answer the questions below using the following scale:
0= Never 1=Seldom 2=Sometimes 3=Often 4=Very Often

1. How often do you have mood swings:	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that is was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine etc) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

(Used with permission 2008 Inflexxion, Inc)
Do you feel unsafe at home or are afraid of anyone at home? ❒Yes ❒ No

_____

Do you have a Health Care Proxy? ❒Yes ❒ No If yes, please bring a copy with you at your next appointment for our records. If not, check here if you are you interested in receiving information ❒

NORTHEAST REHABILITATION HOSPITAL NETWORK

INITIAL ASSESSMENT REV 11/15

REVIEW OF SYSTEMS PLEASE CIRCLE YES OR NO

HEIGHT: _____ WEIGHT: _____

HEENT: **Circle One**

Hearing Loss	Yes	No
Sinus Problem	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Dentures/Partials	Yes	No
Loose Teeth	Yes	No

ENDOCRINE:

Diabetic	Yes	No
Thyroid Disorder	Yes	No

Steroid use Yes No dates:_____
Other Yes No explain: _____

RESPIRATORY:

Asthma	Yes	No
COPD	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Cough	Yes	No
Secretions	Yes	No
Snoring	Yes	No
Sleep Apnea	Yes	No
Airway Obstruction	Yes	No
Hx. Of Tuberculosis	Yes	No
Home Oxygen	Yes	No

CARDIAC:

High Blood Pressure	Yes	No
Chest Pain/Angina	Yes	No
Hx of Heart attack	Yes	No
Murmur	Yes	No
Congestive Heart Failure	Yes	No
Pacemaker	Yes	No
Anemia	Yes	No
Bleeding Disorders	Yes	No

MUSCULOSKELETAL:

Back pain	Yes	No
Arthritis	Yes	No
Osteoporosis	Yes	No
* Amputation	Yes	No
Cast	Yes	No
*Joint replacement	Yes	No
*Artificial Limb	Yes	No

* Please state which extremity and side_____

History of fainting with IV needles or procedures: Yes No

GI:

Change in Appetite	Yes	No
Recent wt.loss/wt.gain	Yes	No
Liver Disease	Yes	No
Hx.Ulcers	Yes	No
Heartburn	Yes	No
Reflux	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Ostomy	Yes	No

GU:

Kidney Pain	Yes	No
Burning	Yes	No
Blood in Urine	Yes	No
Frequency	Yes	No
Hx. Of Infections	Yes	No
Dialysis	Yes	No
Catheter	Yes	No
Ostomy	Yes	No
Hx. Of Kidney Stones	Yes	No

NEURO:

Dizziness	Yes	No
Headaches	Yes	No
Stroke	Yes	No
Fainting	Yes	No
Numbness	Yes	No
Paralysis	Yes	No
Multiple Sclerosis	Yes	No
Paraplegia	Yes	No
Quadraplegia	Yes	No

SKIN:

Sores	Yes	No
Rashes	Yes	No

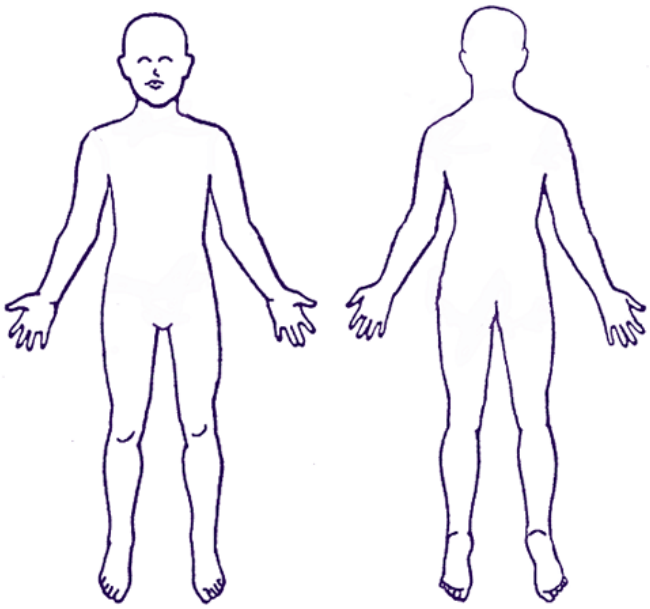
INFECTIOUS DISEASE:

Hx.of Hepatis A/B/C	Yes	No
Hx of HIV/AIDS	Yes	No
Currently on Antibiotics	Yes	No

Date of most recent antibiotic: _____
Recent Fever Yes No

GYN: ❑**NA**

Pregnant Yes No
Last menstrual period: _____



_____ _____ _____

Signature of Person completing this Form Date Time

_____

FOR OFFICE USE ONLY:

BP _____/_____ P _____ R _____

SOAPP score: _____

Comments:

_____

_____

_____

_____

_____

_____

I have reviewed the above information with the patient:

❑ Interpreter: _____

_____ _____ _____

Nurses Signature Date Time