NEW PATIENT PHYSICAL MEDICINE ADDENDUM

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4 Health and Wellness

Patient Name: _____ **Date of birth** ___/___/____ **Today's Date** __/___/___

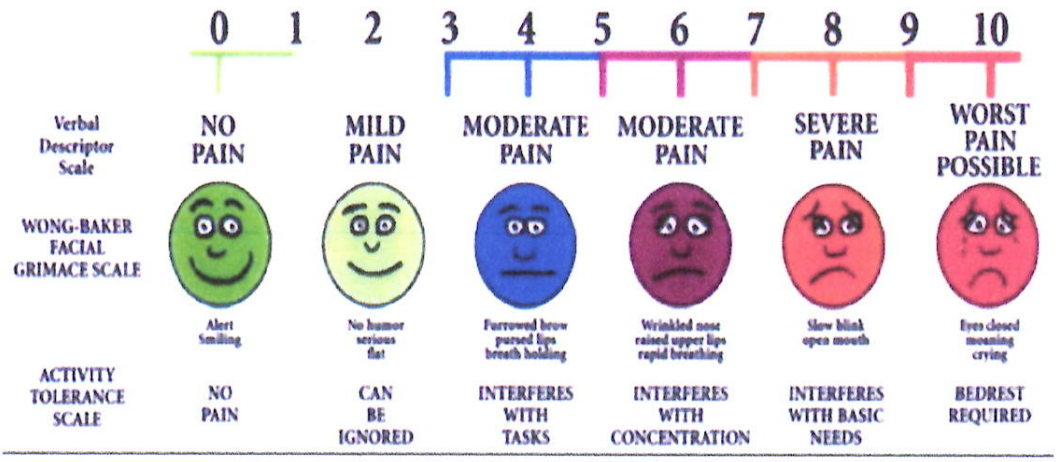
Please use this form if you plan to also fill Doctor Weyrich's INTERNAL MEDICINE INTAKE FORM so that you can avoid answering the same questions twice.

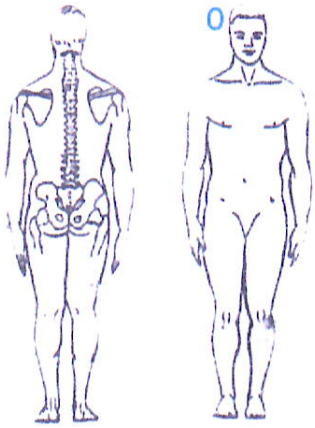
Please list your chief PHYSICAL symptoms and complaints (e.g. pain, stiffness, numbness, tingling) in order of decreasing severity on the following pages, starting with the worst one.

Also write the problem **number** on the picture to the right of the pain scale below to show the location of the pain.

Please note the approximate date you first became aware of the problem in the "Onset" column.

Use the following 0 to 10 pain scale to rate the severity of this problem to you.





PLEASE FILL OUT A SEPARATE SECTION for each complaint, for example:

1. Low back pain
2. Neck pain
3. Etc.

Attach additional pages as necessary

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Version 2023

Symptom/Complaint (where)	Onset	Frequency	Severity
0. e.g. Headache (right forehead)	June 2007	4 times per week	Severe = 10/10
1.			

Is there anything that provokes or makes this complaint worse (e.g. standing, lifting, certain time of day, etc)?

Is there anything that makes this complaint better (e.g. ice, certain time of day, etc)?

What is the quality or character of the pain or symptom (sharp, ache, throbbing, etc)?

Is your complaint constant or does it come and go?

How did it develop (e.g. auto accident, fell, suddenly, slowly, etc)?

Have you been given a diagnosis or explanation (e.g. spinal stenosis, rotator cuff injury, etc)?

What treatments have you tried for this condition, how did that work out?

Has this problem been getting worse, or staying the same?

How does this complaint interfere with what you want or have to do?

Symptom/Complaint (where)	Onset	Frequency	Severity
2.			

Is there anything that provokes or makes this complaint worse (e.g. standing, lifting, certain time of day, etc)?

Is there anything that makes this complaint better (e.g. ice, certain time of day, etc)?

What is the quality or character of the pain or symptom (sharp, ache, throbbing, etc)?

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What is the quality or character of the pain or symptom (sharp, ache, throbbing, etc)?

Is your complaint constant or does it come and go?

How did it develop (e.g. auto accident, fell, suddenly, slowly, etc)?

Have you been given a diagnosis or explanation (e.g. spinal stenosis, rotator cuff injury, etc)?

What treatments have you tried for this condition, how did that work out?

Has this problem been getting worse, or staying the same?

How does this complaint interfere with what you want or have to do?

Have you *recently* (please check all that apply):

- ❑ Had a sudden or unexpected increase in any symptom?
- ❑ Had a fall, motor vehicle accident, or other trauma?
- ❑ Been hospitalized, had surgery, or visited the emergency department/urgent care?
- ❑ Been diagnosed with any new medical condition?
- ❑ Changed medications, nutritional supplements, or other therapies?
- ❑ Had increased pain, numbness, tingling, weakness, or altered sensation in any body part?
- ❑ Experienced an unusually painful headache?
- ❑ Had an increase in dizziness, vertigo, or loss of balance?
- ❑ Experienced a loss of consciousness, seizure, or altered mental status?
- ❑ Noticed an increase in swelling of hands, ankles, feet, or lymph nodes?
- ❑ Noticed a reduction in mental acuity?
- ❑ Had an animal, insect, or spider bite causing swelling or persistent pain?
- ❑ Coughed up or vomited blood?
- ❑ Had bloody urine, painful urination, incontinence, or changes in character of urine?
- ❑ Experienced a change in bowel habits, anal incontinence, or changes in character of stool?
- ❑ Noticed numbness in the groin or anal regions?
- ❑ Noticed nipple retraction or discharge, breast lumps or dimples, or had unexpected vaginal bleeding?
- ❑ Noticed an increase in shortness of breath, blue lips, or nail-beds?
- ❑ Had an increase of cough or throat pain?
- ❑ Had a change in vision, double vision, or eye pain?
- ❑ Had a fever, chills, or increase in night sweats?
- ❑ Had a change in hearing, drainage of fluids from ear, ringing in the ear, or ear pain?
- ❑ Been diagnosed with any bone disease?
- ❑ Experienced increase of abdominal pain?
- ❑ Experienced unexpected weight loss or gain?
- ❑ Experienced chest pain?
- ❑ Experienced facial pain or unusual sinus drainage?
- ❑ Experienced leg or thigh pain that is worse on exertion (walking, standing, etc)?
- ❑ Experienced swelling or itching of lips following insect sting, food, herb, supplement, or drug?
- ❑ Experienced a change in sexual function?
- ❑ Experienced sudden, severe anxiety, smothering sensation, and chest pain?
- ❑ Felt pessimistic, hopeless, and helpless?
- ❑ Ever been diagnosed or thought you had cancer?
- ❑ Had pain that is worse at night lying in bed?
- ❑ Ever used IV street drugs?
- ❑ Ever been treated with immune suppressing drugs?
- ❑ Do you have any "hardware" in your body (pace maker, screws, etc)?
- ❑ Are you pregnant?
- ❑ None of the above

Patient signature: _____ **Date** _____