New Patient Evaluation Form

OMEGA Rehabilitation & Spine

General Information

Your Name _____ Today's Date _____

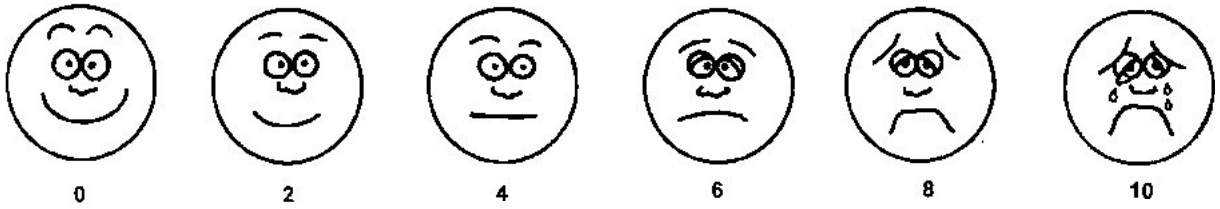
Date of Birth: _____ Height: _____ ft. _____ in. Weight: _____ Age: _____

Referred By: _____ Family Physician: _____

Date onset of pain: _____ Cause of Pain: _____

Was this injury: ☐ At Work ☐ Auto Accident ☐ Other ☐ After Surgery

Onset of pain: ☐ Sudden ☐ Gradual

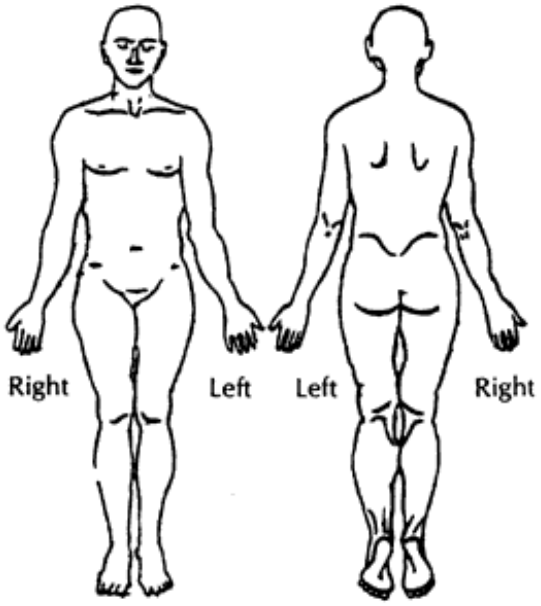


0	2	4	6	8	10
No hurt	Hurts a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts the worst

On a scale of 1-10 your pain is at its worst: _____ Pain at its best: _____ Pain at this moment: _____

Location of Your Pain

On the picture, color in all your areas of pain.



Associated with (check all that apply):

Associated with (check all that apply) :

☐ Numbness/Tingling

☐ Night Pain

Weakness

☐ Loss of Control of Bowel

☐ Loss of Control of Bladder

☐ Fever/Chills

☐ Sexual Dysfunction

☐ Unexplained Weight Loss

How many pounds: _____