Weill Cornell Medicine
Rehabilitation Medicine

Welcome!

Jaclyn Bonder, MD

Please Note: All information is confidential and will become a part of your medical record. Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. PLEASE PRINT CLEARLY

Patient Name:	Date of Visit:
Date of Birth:	Social Security Number:
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner
Home Address:	Home Phone Number: Other Phone Number:
Preferred Email Address:	Emergency Contact Name and Number: Relationship to Patient:
Primary Insurance Carrier:	Insurance ID Number:
Insurance Phone Number:	Are you the Primary Insurance Policy Holder? ☐ Yes ☐ No
If No, Please list the Name and Date of Birth of the Policy Holder:	
Does Your insurance plan require referrals for specialty visits? ☐ Yes ☐ No	If YES, do you have a referral for today's visit? ☐ Yes ☐ No

T. 212.746.1500 | F. 212.746.8303 | rehab@med.cornell.edu

Physician and Pharmacy Information

Referring Physician

Name:

Phone:

Fax :

Primary Care Provider

Name:

Phone:

Fax:

Were you referred for a Consultation?

☐ Yes ☐ No

Preferred Pharmacy

Name:

Phone:

Fax:

Did you sustain your injury on the job or during a motor vehicle accident?

☐ Yes ☐ No

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize the holder of medical information about me to release to my insurance and, if I am a Medicare patient, to the Centers for Medicare and Medicaid Services and its agents, any information necessary to determine these benefits or the benefits payable for related services. I request that payment of any benefits be made on my behalf to the provider of services. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for payment in full for these services including any amounts not paid by my insurance carrier such as Copayments, Deductibles, and other non-covered services.

I understand that services deemed non-medically necessary are not covered by my insurance carrier and that I will be financially responsible for any such non-covered services.

Signature Date

T. 212.746.1500 | F. 212.746.8303 | rehab@med.cornell.edu

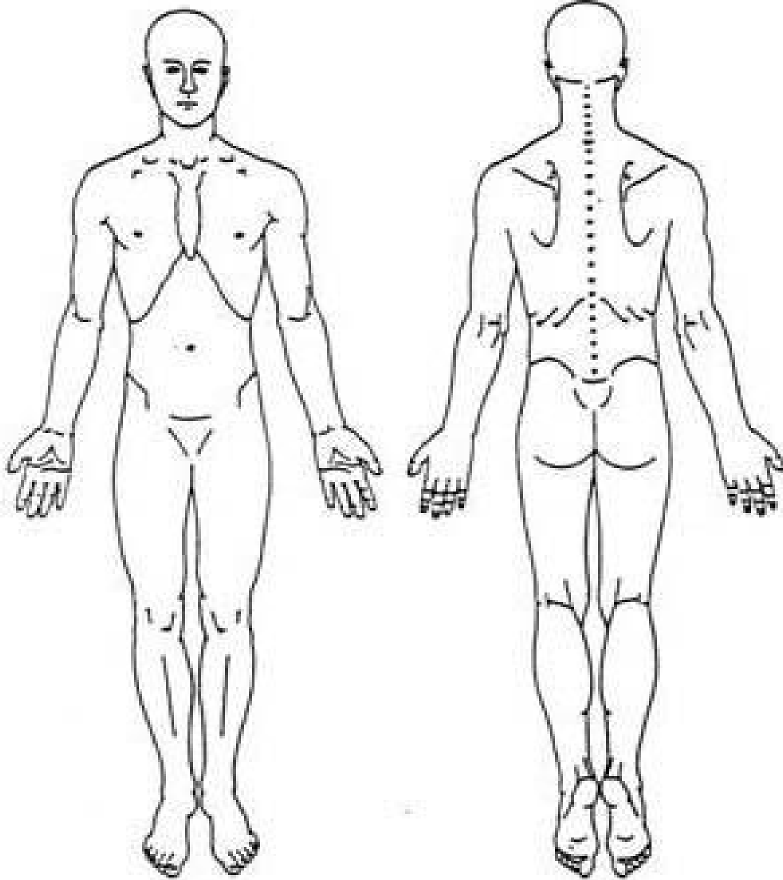
Weill Cornell Medicine
Rehabilitation Medicine

☐ SCQ

BP_____ Pulse_____
HT_____ WT_____

Patient Name:	Patient Date of Birth:
Why are you here today?	Referring Provider:
Duration of symptoms?	
How did it begin?	

Please complete the pain drawing below by marking where you feel pain right now on the figures below.
(If you do not feel pain, please skip to page 2)



RATE YOUR PAIN ON A SCALE OF 0 TO 10
(0 = no pain 10 = extreme pain)

1. Right Now: 0 1 2 3 4 5 6 7 8 9 10
2. At Best: 0 1 2 3 4 5 6 7 8 9 10
3. At Worst: 0 1 2 3 4 5 6 7 8 9 10
4. What does the pain feel like (check all that apply)?

☐ Sore	☐ Aching	☐ Burning
☐ Shooting	☐ Throbbing	☐ Dull
☐ Tender	☐ Stabbing	☐ Tingling
☐ Sharp	☐ Pulling	☐ Cramping
☐ Radiation	☐ Unsure	

5. What makes it better (check all that applies)?

☐ Heat	☐ Cold	☐ Bending Forward
☐ Sitting	☐ Standing	☐ Bending Back
☐ Walking	☐ Twisting	☐ Lying Down
☐ Coughing	☐ Sneezing	☐ Weather Change
☐ Sexual Intercourse		☐ Nothing

6. What makes it worse (check all that applies)?

☐ Heat	☐ Cold	☐ Bending Forward
☐ Sitting	☐ Standing	☐ Bending Back
☐ Walking	☐ Twisting	☐ Lying Down
☐ Coughing	☐ Sneezing	☐ Weather Change
☐ Sexual Intercourse		☐ Nothing

7. Since the pain began, is it (check one): ☐ getting better ☐ getting worse ☐ staying the same
8. Have you ever had pain in this area prior to this episode? ☐ NO ☐ YES If yes, when? ____________________
9. Have you had any recent falls? ☐ NO ☐ YES
10. How far can you walk?
11. Do you require an assistive device (e.g., cane, brace)? ☐ NO ☐ YES

12. Do you need help with household activities? ☐ NO ☐ YES

Do you have any of the following symptoms (check all that apply)?

☐ Easy Bleeding/Bruising ☐ Weight Change ☐ Breathing Problems ☐ Fever/Chills ☐ Heart Problems
☐ Stomach Problems ☐ Joint pain/ Swelling ☐ Morning Stiffness ☐ Weakness ☐ Skin Problems
☐ Bowel/Bladder Changes ☐ Night Pain ☐ Depression/Anxiety ☐ Numbness ☐ Tingling
☐ Shortness of Breath ☐ Vision Change ☐ Sleep Problems ☐ Headaches ☐ Chest Pain
☐ Rash ☐ Other____________

Have you had any of the following tests or treatments for your current problem?

	NO	YES	Date(s)		NO	YES	Date(s)
X-Rays	☐	☐	___________	EMG (Nerve Test)	☐	☐	___________
CT Scan	☐	☐	___________	Bone Scan	☐	☐	___________
MRI Scan	☐	☐	___________	Injection	☐	☐	___________
Surgery	☐	☐	___________	Physical Therapy	☐	☐	___________
Medications	☐	☐	___________				

If yes, list names of medications for current problem ____

Medical History		
Past Medical Problems:	Past Surgeries	Dates
Name All Current Medications:	List Any Medication Allergies	

Do you have allergies to any of the following?

☐ Shellfish ☐ Iodine ☐ Contrast/ IV Dye ☐ Latex

Does anyone in your family have any of the following medical problems?

Family Member	Alive	Arthritis	Cancer	Heart Disease	Diabetes	Other
	☐ Y ☐ N					
	☐ Y ☐ N					
	☐ Y ☐ N					

Have you received the Pneumonia Vaccination? ☐ No ☐ Yes Date:________/____/______
Have you received the Influenza Immunization? ☐ No ☐ Yes Date:________/____/______

Social History

<table>
<tr>
<td>

Do you smoke?

☐ Yes

How many packs per day? ___

☐ Not currently, but I used to.

Quit date: ____/____/_____

☐ No

</td>
<td>

Do you consume alcohol

☐ Yes

How many drinks in one week? ___

☐ No

</td>
</tr>
<tr>
<td>

Current Residence:

☐ House

☐ Apartment

☐ Other

Stairs? ☐ Yes ☐ No

Elevator? ☐ Yes ☐ No

</td>
<td>

Employment Status:

☐ Full Time ☐ Part Time

☐ Retired ☐ Student

☐ Unemployed ☐ Disability

☐ Worker's Compensation

If applicable, what is your occupation?

____

</td>
</tr>
</table>

Urinary Symptoms

Do you experience any of the following?

Urinary incontinence (leakage of urine or urinary accidents) ☐ NO ☐ YES

If YES: (check all that apply)

☐ With: coughing/sneezing/laughing/exercise ☐ Occurs suddenly without warning

☐ Started during pregnancy ☐ Started after delivery of my baby

☐ Occurs because I cannot walk well enough to get to the bathroom on time

Feeling like you suddenly need to urinate ☐ NO ☐ YES

Feeling you urinate too frequently ☐ NO ☐ YES: How many times per day? ___

Feeling like you cannot empty your bladder fully ☐ NO ☐ YES

Cannot start your urine stream ☐ NO ☐ YES

Wake up to urinate more than 2x per night ☐ NO ☐ YES: How many times per night? ___

Pain with urination ☐ NO ☐ YES

Gastrointestinal

Do you experience any of the following?

Fecal incontinence (leakage of feces or bowel accidents) ☐ NO ☐ YES

Difficulty holding bowel movements or gas ☐ NO ☐ YES

Constipation ☐ NO ☐ YES: How many bowel movements per week?____

Do you have increased pain with bowel movements? ☐ NO ☐ YES

Does your pain improve after completing a bowel movement? ☐ NO ☐ YES

Sexual History

Are you currently sexually active? ☐ NO ☐ YES

Do you experience pain with sexual intercourse? ☐ NO ☐ YES

If YES: (check all that apply)

☐ With initial penetration ☐ Deep pain during sex

☐ With orgasms ☐ Because of body/leg positioning

History of sexually transmitted disease? ☐ NO ☐ YES

History of sexual problems? (i.e. erectile dysfunction, inability to have an orgasm) ☐ NO ☐ YES

Additional Medical History

Do you have a history of?

Depression ☐ NO ☐ YES

Anxiety ☐ NO ☐ YES

If YES: Are you treated with medications?

☐ Currently ☐ In the past ☐Never

Are you treated with counseling?

☐ Currently ☐ In the past ☐ Never

Do you have trouble sleeping? ☐ NO ☐ YES

If YES: (check all that apply)

☐ Difficulty falling asleep ☐ Difficulty staying asleep

☐ Because of pain ☐ Because of racing thoughts, worry, or other

Have you ever:

Been abused? ☐ NO ☐ YES

Had an eating disorder? ☐ NO ☐ YES

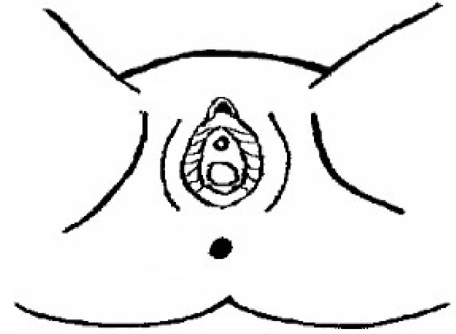
Felt unsafe at home or scared of your spouse/partner others? ☐ NO ☐ YES

FOR WOMEN ONLY (MEN PLEASE SKIP THE REMAINING QUESTIONS)

Vulvar / Perineal Pain

(Pain outside and around the vagina and anus)

If you have vulvar pain, shade in the painful areas on the diagram:



Information about Your Pain

What typed of treatments / providers have you tried in the past for your pain? (Check all that apply)

☐ Acupuncture
☐ Anesthesiologist
☐ Anti-seizure medications
☐ Antidepressants
☐ Biofeedback
☐ Botox injection
☐ Contraceptive
☐ Danazol (Danocrine)
☐ Depo-Provera
☐ Gastroenterologist
☐ Gynecologist
☐ Family Practitioner
☐ Herbal Medicine
☐ Homeopathic Medicine
☐ Lupron, Synarel, Zoladex
☐ Massage
☐ Meditation
☐ Narcotics
☐ Naturopathic Medication
☐ Nerve blocks
☐ Neurosurgeon
☐ Nonprescription medicine
☐ Nutrition/Diet
☐ Physical Therapy
☐ Psychotherapy
☐ Psychiatrist
☐ Rheumatologist
☐ Skin Magnets
☐ Surgery
☐ TENS unit
☐ Trigger point
☐ Urologist

☐ Other:__________________________

Obstetrical History

When was your last menstrual period?______/______/_______

Are you pregnant? ☐ NO ☐ YES; # of weeks___

Number of pregnancies? _______

Number of children? ________

Ages of your children? ___________________________

Are you currently breastfeeding? ☐ NO ☐ YES

Did you have back pain during your pregnancy? ☐ NO ☐ YES

How long was your last labor?_____________________

How long was your pushing phase? ________________

What type of delivery/deliveries? (Check all that apply)

☐ Vaginal ☐ C-section ☐ Vacuum ☐ Forceps

Have you had an episiotomy or tearing of vagina or rectum? ☐ NO ☐ YES

Any complications during pregnancy? (Check all that apply)

☐ Hypertension ☐ Bleeding ☐ Contractions ☐ Diabetes
☐ Back Pain ☐ Pelvic Pain ☐ Bed Rest ☐ Other_______________