



Rheumatology Center of Princeton

123 Franklin Corner Rd. Suite 106, Lawrenceville NJ 08648, Phone Number: 609-896-2505

Dr. Gina Del Giudice, M.D., FACR, FACP
Michael J. Froncek, M.D., MS, FACP, FACR

INITIAL PATIENT HISTORY AND HEALTH ASSESMENTS

Please take a few minutes to fill out the information on all six pages as completely as you can. Any information you can give on this form will help in our care for you; if you cannot fill out a section, please skip it and move on. Thank you.

PERSONAL HISTORY:

Name _____ Date of Birth _____

Marital Status: Minor Never Married Married Separated Divorced Widowed

Spouse/Significate Other: Alive / Age: ____ Deceased / Age: ____ Major Illnesses: _____

Education: Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School **Employment:** F/T P/T Student Homemaker Retired Disabled Unemployed Other

Occupation _____ Number of Hours Worked / Average per Week _____

Referred here by: Self Family Friend Doctor Other Health Professional Other

Name of Referral Source: _____

Name of your Primary Care Provider _____

SOCIAL HISTORY:

Do you drink caffeinated beverages Yes No If Yes, Cups / Glasses per day: _____

Do you smoke? Never Yes: Packs / Day: ____ # Years: ____ Quit?: How Long Ago? ____

Do you drink alcohol? Yes: Number of Drinks per Week: ____ No

Has anyone ever told you to cut down on your drinking? Yes No

Do you exercise regularly? Yes No Type: _____ Amount per Week: _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? Yes No Do you wake up feeling rested? Yes No

FAMILY HISTORY:

IF LIVING			IF DECEASED	
	AGE	HEALTH	AGE AT DEATH	CAUSE
FATHER				
MOTHER				

Number of siblings: _____

Number Living: _____

Number Deceased: _____

Number of Children: _____

Number Living: _____

Number Deceased: _____

List age / health of each child: _____

MEDICAL HISTORY:

As you review the following list, please check any items which have significantly affected you.

<p>CONSTITUTIONAL</p> <input type="checkbox"/> Recent weight gain Amount: _____	<p>EARS NOSE-MOUTH-THROAT</p> <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Loss of smell <input type="checkbox"/> Dryness in Nose <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sore Tongue <input type="checkbox"/> Bleeding Gums	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Pain in chest <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Sudden changes in heart beat <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmurs	<p>NEUROLOGICAL SYSTEM</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Muscle Spasm <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Sensitivity or pain in hands/feet <input type="checkbox"/> Memory loss <input type="checkbox"/> Night sweats
<p>SKIN AND /OR BREAST</p> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Redness <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Sun Sensitivity (sun allergy) <input type="checkbox"/> Tightness <input type="checkbox"/> Nodules / Bumps <input type="checkbox"/> Hair Loss <input type="checkbox"/> Color changes of hand or feet in cold	<p>ENDOCRINE</p> <input type="checkbox"/> Excessive thirst	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting of blood or "coffee grounds" material <input type="checkbox"/> Stomach pain relieved by food or milk <input type="checkbox"/> Jaundice <input type="checkbox"/> Increasing Constipation <input type="checkbox"/> Persistent diarrhea <input type="checkbox"/> Blood in stools <input type="checkbox"/> Black stools <input type="checkbox"/> Heartburn	<p>PSYCHIATRIC</p> <input type="checkbox"/> Excessive worries <input type="checkbox"/> Anxiety <input type="checkbox"/> Easily losing temper <input type="checkbox"/> Depression <input type="checkbox"/> Agitation <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep
<p>ALLERGIC /IMMUNOLOGIC</p> <input type="checkbox"/> Frequent sneezing <input type="checkbox"/> Increased susceptibility to infection	<p>HEMATOLOGIC/LYMPHATIC</p> <input type="checkbox"/> Swollen glands <input type="checkbox"/> Tender glands <input type="checkbox"/> Anemia	<p>GENITOURINARY</p> <input type="checkbox"/> Difficult urination <input type="checkbox"/> Pain or burning on urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Cloudy, "smoky" urine	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> Morning stiffness How long? _____
<p>EYES</p> <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Loss of vision <input type="checkbox"/> Double or blurred vision <input type="checkbox"/> Dryness <input type="checkbox"/> Feels like "something in eye" <input type="checkbox"/> Itching eyes	<p>RESPIRATORY</p> <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Transfusion When: _____	<p>GENITOURINARY</p> <input type="checkbox"/> Pus in urine <input type="checkbox"/> Discharge from penis / vagina <input type="checkbox"/> Getting up at night to urinate <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Rash / Ulcers <input type="checkbox"/> Sexual difficulties <input type="checkbox"/> Prostate Trouble	<p>JOINT PAIN</p> <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint swelling List Joints Affected _____ _____ _____ _____

FOR WOMEN ONLY

Age when periods began: _____

Periods regular? Yes No

How many days apart: _____

Date of last period: _____

Date of last pap: _____

Bleeding after menopause Yes No

Number of pregnancies: _____

Number of miscarriages: _____ Contraceptive Method: _____

PAST MEDICAL HISTORY: Do you now have, or have you ever had (Check if Yes)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthmas | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Bad Headaches | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Goiter | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Tuberculosis |
- Other Significant Illnesses (Please List): _____

PAST SURGICAL HISTORY: Operations you have had:

	TYPE	Year	Reason
1			
2			
3			
4			
5			

Any previous fractures? No Yes Describe: _____

Any other serious injuries? No Yes Describe: _____

Date of last Eye Exam: _____

Date of last Bone Densitometry: _____

Date of last Mammogram: _____

Date of last Chest X-ray: ____

Date of last Tuberculosis test: _____

Date of last Pap Smear / PSA: _____

MEDICATIONS: Please list any medications you are currently takin, INCLUDING such items as aspirin, vitamins, laxative, calcium, herbal supplement, etc.

	Name of Drug	Dose (Include Strength & number of pills per day)	How long have you taken this medication?	Please Check: HELPED?		
				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
1				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
2				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
3				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
4				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
5				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
6				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
7				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
8				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
9				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
10				<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No

Drug Allergies: NONE Yes To what? _____

CURRENT MEDICAL HISTORY:

Please describe briefly your present symptoms. (In other words, what brings you to us today?)

About when did these symptoms begin?

CURRENT MEDICAL HISTORY (Continued)

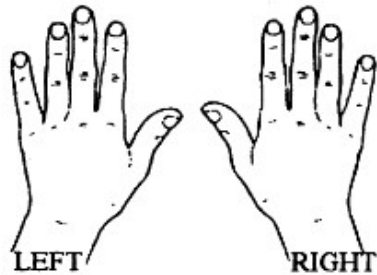
Have you been previously treated for this problem? Yes___ No___

What kind of treatment? Medication Physical Therapy Injection Surgery Other

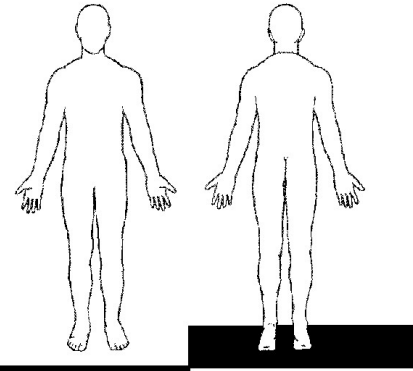
Please list the names of other practitioners you have seen for this problem. _____

Please indicate all area you have had pain over the past week on the body figures and hands.

XXXXX = PAIN = BURNING ----- = TINGLING



(Please indicate palms of hands on body)



RHEUMATOLOGIC / ARTHRITIS HISTORY

At any time, have you or a blood relative had any of the following? (Check if "Yes")

			Relationship				Relationship
Arthritis (unknown type)	<input type="checkbox"/> Self	<input type="checkbox"/> Relative		Lupus or "SLE"	<input type="checkbox"/> Self	<input type="checkbox"/> Relative	
Osteoarthritis	<input type="checkbox"/> Self	<input type="checkbox"/> Relative		Rheumatoid Arthritis	<input type="checkbox"/> Self	<input type="checkbox"/> Relative	
Gout	<input type="checkbox"/> Self	<input type="checkbox"/> Relative		Ankylosing Spondylitis	<input type="checkbox"/> Self	<input type="checkbox"/> Relative	
Childhood Arthritis	<input type="checkbox"/> Self	<input type="checkbox"/> Relative		Osteoporosis	<input type="checkbox"/> Self	<input type="checkbox"/> Relative	
Other Arthritis	<input type="checkbox"/> Self	<input type="checkbox"/> Relative		Other Arthritis	<input type="checkbox"/> Self	<input type="checkbox"/> Relative	

PAST MEDICATIONS:

Please review this list of "arthritis" medications. As accurately as possible try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication, and list any reactions you may have had.

Drug Names / Dosage	Length of Time	Please Check: Helped?			Reactions / Comments
		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
NSAIDS					
Ansaid (flurbiprofen)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Arthrotec (Diclofenac&Misoprostol)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Aspirin (Including coated aspirin)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Celebrex (Celecoxib)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Clinoril (Sulindac)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Daypro (Oxaprozin)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Disalcid (Salsalate)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Dolobid (Diflunisal)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Feldene (Piroxicam)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Indocin (Indomethacin)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Lodine (Etodolac)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Meclomen (Meclofenamate)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Motrin/Advil/Rufen (Ibuprofen)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	

Name: _____ Date: _____ Age: _____ Sex: M F

Drug Names / Dosage	Length of Time	Reactions / Comments		
NSAIDS (Continued)				
Oruvail/Orudis (Ketoprofen)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Tolectin (Tolmetin)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Trilisate (Choline Magnesium Trisallylate)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Vioxx (Rofecoxib)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Voltaren (Difofenac)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
PAIN RELIEVERS				
Acetaminophen (Tylenol)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Codeine (Vicodin, Tylenol #3)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Propoxphene (Darvon/Darvocet)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Other:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Other:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
ANTI-RHEUMATIC DRUGS				
Auranofin, Gold pill (Ridaura)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Gold shots (Myochrysin or Golganol)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Methotrexate (Rheumatrex)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Azathioprine (Imuran)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Sulfasalazine (Azulfidine)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Quinacrine (Atabrine)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Cyclophosphamide (Cytoxan)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Etanercept (Enbrel)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Infliximab (Remicade)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Prosorba Column		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Tocilizumab (Actemra)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Certolizumab (Cimzia)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Adalimumab (Humira)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Anakinra (Kineret)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Abatacept (Orencia)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Rituximab (Rituxan)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Golimumab (Simponi)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Golimumab (Simponi Aria)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Sarilumab (Kevzara)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Secukinumab (Cosentyx)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Ixekizumab (Taltz)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Ustekinumab (Stelara)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Risankizumab (Skyrizi)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Tildrakizumab (Ilumya)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Canakinumab (Ilaris)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Rilonacept (Arcalyst)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Tofacitinib (Xeljanz)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Baricitinib (Olumiant)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Upadacitinib (Rinvoque)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Other:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Other:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
OSTEOPOROSIS MEDICATIONS				
Estrogen (Premarin, etc.)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Alendronate (Fosamax)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Etidronate (Didronel)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Raloxifene (Evista)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Fluoride		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Calcitonin injection/nasal (Miacalin, Calcimar)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Residronate (Actonel)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No
Other:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No

Other:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
GOUT MEDICATIONS					
Probenecid (Benemid)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Colchicine		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Allopurinol (Zyloprim/Loquirin)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Other:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Other:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
OTHERS					
Tamoxifen (Nolvadex)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Tiludronate (Skelid)		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Cortisone / Prednisone		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Hyalgan / Synvisc Injections		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
HERBAL OR NUTRITIONAL SUPPLEMENTS					
Supplements:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Supplements:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Supplements:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	
Supplements:		<input type="checkbox"/> A lot	<input type="checkbox"/> Some	<input type="checkbox"/> No	

Have you participated in any clinical trials for new medications No Yes

If Yes, Please list: _____

Name: _____ Date: _____ Age: _____ Sex: M F

Considering all the ways in which illness and health conditions may affect you At this time, please make a mark below to show how you are doing:

Very Well |-----| Very Poorly

How much pain have you had because of your condition over the past week? Place a mark on the line below to indicate how severe your pain has been:

No Pain |-----| Unbearable Pain

Please answer the following questions, even if you feel that they may not be related to you at this time.

Answer exactly as you think or fee there are no "right" or "wrong" answers.

Check the one best answer for each question.

For Official Use Only

GL

0-100

PN

0-100

FN EQUALS

- 1 = 0.33
- 2 = 0.87
- 3 = 1.0
- 4 = 1.33
- 5 = 1.67
- 6 = 2.0
- 7 = 2.33
- 8 = 2.67
- 9 = 3.0
- 10 = 3.33
- 11 = 3.67
- 12 = 4.0
- 13 = 4.33
- 14 = 4.67
- 15 = 5.0
- 16 = 5
- 17 = 5
- 18 = 6
- 19 = 6
- 20 = 6
- 21 = 7
- 22 = 7
- 23 = 7
- 24 = 8
- 25 = 8
- 26 = 8
- 27 = 9
- 28 = 9
- 29 = 9
- 30 = 1

ACTIVITY LEVEL		Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable to Do
Right now, are you able to:					
1.	Dress yourself, including tying shoelaces and doing buttons?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2.	Get in and out of bed?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3.	Lift a full cup or glass to your mouth?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4.	Walk outdoors on flat ground?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5.	Wash and dry your entire body?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6.	Bend down to pick up clothing from the floor?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7.	Turn regular faucets on and off?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8.	Get in and out of a car, bus, train or airplane?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9.	Walk two miles?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10.	Participate in sports and games as you like?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
FN SUBTOTALS (FOR OFFICE USE ONLY)					
11.	Get a good night sleep?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3
12.	Deal with feelings of anxiety or being nervous?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3
13.	Deal with feeling of depression or feeling blue?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3
PS Subtotals (FOR OFFICE USE ONLY)					

ADDITIONAL INFORMATION YOU WOULD LIKE TO DISCUSS DURING YOUR VISIT TODAY:

Name: _____ Date: _____ Age: _____ Sex: M F