419 E. MAIN ST. JEFFERSON, NC 28640

PHONE 336-846-7227

Legal Name: ____**Nickname:** ___________________

Mailing Address: ____

____

EMAIL ADDRESS: ____

What reminder method do you prefer? □ Email □ Text □ Call

Primary phone number: ______________________ **Secondary phone number:** ______________________

Height: ___________________ **Weight:** _______________________ **DOB:** ______________________

Primary Insurance: ___________________________ **Secondary Insurance:** ________________________

Primary Care Provider: ________________________ **Referring provider:** __________________________

PAST	PRESENT	
□	□	High Blood Pressure
□	□	Pacemaker
□	□	Angina
□	□	Heart Attack
□	□	Stroke
□	□	Congestive Heart Failure
□	□	COPD
□	□	Asthma
□	□	HIV/AIDS
□	□	Systemic Lupus
□	□	Epilepsy
□	□	Rheumatoid Arthritis
□	□	Fibromyalgia
□	□	Diabetes
□	□	Osteoarthritis
□	□	Recent weight loss or gain (unexplained)
□	□	Osteoporosis
□	□	Depression
□	□	Cancer- Location: _______________
□	□	Tobacco- packs/day_______________
□	□	Other:_________________________

Prior hospitalizations / Surgical procedures:

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Medications (dosage/ MG, Times per day):

____

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ALLERGIES:

____

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____

Please describe your current limitation or complaint:

____

____

Please describe **how** and **when** your problem began:

____

____

Indicate the intensity of your pain at best

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Indicate the intensity of your pain at worst

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Your symptoms are worse in:

☐Morning ☐Afternoon ☐Night ☐Increased during the day ☐Same all day

Are you experiencing any issues with balance?

Yes No – If yes, how many falls have you had in the past 6 months?_________________

Have you had any other treatment for this condition?

Yes No - If yes, please indicate treatment ______________________________________

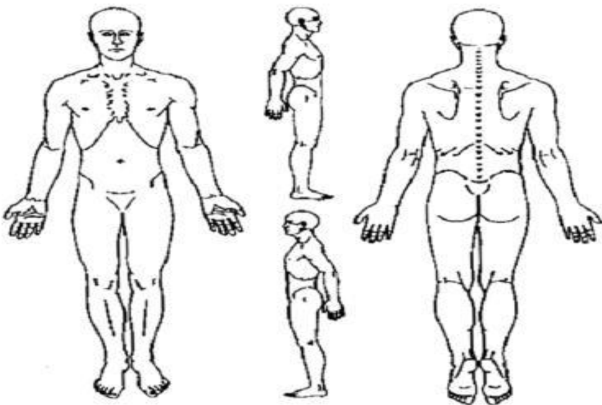
Was this treatment effective: Yes No

Occupation: ___________________

Has your work status changed because of this condition? Yes No

Is this the result of a work-related injury? Yes No

Was this the result of a motor vehicle accident? Yes No



Please describe the nature of your pain by marking the following image

○ *Sharp pain* ○ *Numbness*

○ *Dull/ ache* ○ *Shooting*

○ *Throbbing* ○ *Burning*

How did you hear about Schuster Physical Therapy? _______________________________

Modified Fatigue Impact Scale (MFIS)

Fatigue is a feeling of physical tiredness and lack of energy that many people experience from time to time. But people who have medical conditions like MS experience stronger feelings of fatigue more often and with greater impact than others.

Following is a list of statements that describe the effects of fatigue. Please read each statement carefully, the circle the one number that best indicates how often fatigue has affected you in this way during the past 4 weeks. (If you need help in marking your responses, tell the interviewer the number of the best response.) Please answer every question. If you are not sure which answer to select choose the one answer that comes closest to describing you. Ask the interviewer to explain any words or phrases that you do not understand.

Because of my fatigue during the past 4 weeks

		Never	Rarely	Sometimes	Often	Almost Always
1.	I have been less alert.	0	1	2	3	4
2.	I have had difficulty paying attention for long periods of time.	0	1	2	3	4
3.	I have been unable to think clearly.	0	1	2	3	4
4.	I have been clumsy and uncoordinated.	0	1	2	3	4
5.	I have been forgetful.	0	1	2	3	4
6.	I have had to pace myself in my physical activities.	0	1	2	3	4
7.	I have been less motivated to do anything that requires physical effort.	0	1	2	3	4
8.	I have been less motivated to participate in social activities.	0	1	2	3	4
9.	I have been limited in my ability to do things away from home.	0	1	2	3	4
10.	I have trouble maintaining physical effort for long periods.	0	1	2	3	4
11.	I have had difficulty making decisions.	0	1	2	3	4
12.	I have been less motivated to do anything that requires thinking	0	1	2	3	4
13.	My muscles have felt weak	0	1	2	3	4
14.	I have been physically uncomfortable.	0	1	2	3	4
15.	I have had trouble finishing tasks that require thinking.	0	1	2	3	4
16.	I have had difficulty organizing my thoughts when doing things at home or at work.	0	1	2	3	4
17.	I have been less able to complete tasks that require physical effort.	0	1	2	3	4

		Never	Rarely	Sometimes	Often	Almost Always
18.	My thinking has been slowed down.	0	1	2	3	4
19.	I have had trouble concentrating.	0	1	2	3	4
20.	I have limited my physical activities.	0	1	2	3	4
21.	I have needed to rest more often or for longer periods.	0	1	2	3	4

Instructions for Scoring the MFIS

Items on the MFIS can be aggregated into three subscales (physical, cognitive, and psychosocial), as well as into a total MFIS score. All items are scaled so that higher scores indicate a greater impact of fatigue on a person's activities.

Physical Subscale

This scale can range from 0 to 36. It is computed by adding raw scores on the following items: 4+6+7+10+13+14+17+20+21. 0

Cognitive Subscale

This scale can range from 0 to 40. It is computed by adding raw scores on the following items: 1+2+3+5+11+12+15+16+18+19. 0

Psychosocial Subscale

This scale can range from 0 to 8. It is computed by adding raw scores on the following items: 8+9. 0

Total MFIS Score

The total MFIS score can range from 0 to 84. It is computed by adding scores on the physical, cognitive, and psychosocial subscales. 0