Dear New Patient,

Welcome and thank you for choosing Marshall Rheumatology. We look forward to working with you and providing the best care possible.

Please take a few moments to complete the enclosed New Patient Paperwork. Please mail completed paperwork in the enclosed envelope, or simply bring it to our location. An appointment will not be scheduled until records have been received from your physician/referring physician or previous Rheumatologist, making it important for us to receive the records release form included.

Thank you for your trust in Marshall Rheumatology and we look forward to serving you!

Sincerely,

Dr. Randall Beyl and Staff of Marshall Rheumatology
**PATIENT INFORMATION (PLEASE PRINT)**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Referred By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Primary Work ( )</td>
</tr>
<tr>
<td>( )</td>
<td>Y / N Phone:</td>
</tr>
<tr>
<td>E-mail Address:</td>
<td></td>
</tr>
</tbody>
</table>

Please check if you do NOT have an e-mail address: ______
(We will NOT e-mail you. This is for Patient Portal Messaging only.)

<table>
<thead>
<tr>
<th>Race (please circle):</th>
<th>White Black Asian Indian/Alaskan Pac. Isle Other/Multo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity (please circle):</td>
<td>Hispanic Non-Hispanic Language:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient's Employer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer's Address:</td>
</tr>
<tr>
<td>Spouse's Employer:</td>
</tr>
<tr>
<td>Responsible Party:</td>
</tr>
</tbody>
</table>

**INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>PRIMARY Insurance Company</th>
<th>Contract Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder Name</td>
<td>Group Number</td>
</tr>
<tr>
<td>SECONDARY Insurance Company (if applicable)</td>
<td>Contract Number</td>
</tr>
<tr>
<td>Policy Holder Name</td>
<td>Group Number</td>
</tr>
</tbody>
</table>

What is your copay amount? $____________________

Are you retired? ☐ Yes ☐ No Is your spouse retired? ☐ Yes ☐ No

Are you being seen because of an auto accident or an on-the-job injury? ☐ Yes ☐ No

We request payment at the time of service. If we participate with your insurance plan, you are required to pay your copayment and / or deductible at the time of service. We do participate with Medicare. I give my permission to release any and / or all information contained in my chart necessary to process my insurance claims.

Signature of Patient or Responsible Party: ________________________________ Date: _________________

---

**Marshall Rheumatology**
Patient Contact Information

Patient Name ______________________________________________________

Date of Birth ______________________________________________________

Please list a secure phone number to leave voice messages.

Home phone # (            )______________________

Cell phone # (            ) ______________________

☐ Please check this box, if you do not want us to leave a voice mail message.

Name of person to notify in case of emergency **not living in your home.**

1. ______________________________________________________________________________________
   
   Name _____________________________________________
   
   Relationship
   
   Home phone # (            ) ______________________
   
   Cell phone # (            ) ______________________

2. ______________________________________________________________________________________
   
   Name _____________________________________________
   
   Relationship
   
   Home phone # (            ) ______________________
   
   Cell phone # (            ) ______________________

Additional Contacts

_______________________________________________________________________________________

_______________________________________________________________________________________

Please update every six months.
New Patient Consent to the Use and Disclosure of Health information for Treatment, Payment or Healthcare Operations

I, ________________________________, understand that, as part of my health care, Marshall Rheumatology originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment.
A means of communication among the many health professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party payer can verify that services billed were actually provided.
A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

I understand and have been offered a Privacy Notice that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent.
The right to object to the use of my health information for directory purposes.
The right to request restrictions as to how my health information may be used or disclosed to effect treatment, payment or health care operations.

I understand that Marshall Rheumatology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Marshall Rheumatology reserves the right to change their notice and practices prior to implementation and in accordance with Section 164.520 of the Code of Federal Regulations. Should Marshall Rheumatology change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient's Signature ___________________________________________ Date __________________________
Authorization to Release Health Information

Patient's Name: ______________________________ Date of Birth: ______________________

Social Security #: _____________________________

I, _______________________________________________________________ request and authorize:

Name of Provider: ________________________________________________________

Phone: __________________________________________________________________

City: _________________________ State: _____________ Zip Code: _______________

___________________________ ______________
Patient's Signature Date

to release the following healthcare information of the patient named above to Marshall Rheumatology:

- H &P
- Last Office Summary
- Medication List
- Laboratories
- X-rays
- Echocardiograms
- Immunizations

___________________________ ______________
Patient's Signature Date
**Patient History Form**

**Date of first appointment:** / /  
**Time of appointment:**  
**Birthplace:**

**Name:**  
**Birthdate:** / /  
**Age:**  
**Sex:** M

**Address:**  
**Telephone:** Home ( )  
**Work** ( )

**MARITAL STATUS:**  
- Never Married  
- Married  
- Divorced  
- Separated  
- Widowed

**Spouse/Significant Other:**  
- Alive/Age  
- Deceased/Age  
**Major Illnesses**

**EDUCATION** (circle highest level attended):  
- Grade School  
- College  
- Graduate School

**Occupation**  
**Number of hours worked/average per week**

**Referred here by:** (check one)  
- Self  
- Family  
- Friend  
- Doctor  
- Other Health Professional

**Name of person making referral:**

**The name of the physician providing your primary medical care:**

**Do you have an orthopedic surgeon?**  
- Yes  
- No  
If yes, Name:

**Describe briefly your present symptoms:**

**Date symptoms began** (approximate):  
**Example**

**Diagnosis:**

**Previous treatment for this problem** (include physical therapy, surgery and injections; medications to be listed later)

**Please list the names of other practitioners you have seen for this problem:**

---

**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

At any time have you or a blood relative had any of the following? (check if “yes”)

<table>
<thead>
<tr>
<th>Yourself</th>
<th>Relative Name/Relationship</th>
<th>Yourself</th>
<th>Relative Name/Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis (unknown type)</td>
<td></td>
<td>Lupus or &quot;SLE&quot;</td>
<td></td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td></td>
<td>Rheumatoid Arthritis</td>
<td></td>
</tr>
<tr>
<td>Gout</td>
<td></td>
<td>Ankylosing Spondylitis</td>
<td></td>
</tr>
<tr>
<td>Childhood arthritis</td>
<td></td>
<td>Osteoporosis</td>
<td></td>
</tr>
<tr>
<td>Other arthritis conditions:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please shade all the locations of your pain **over the past week** on the body figures and hands.

**SYSTEMS REVIEW**

As you review the following list, please check any of those problems, which have significantly affected you.

<table>
<thead>
<tr>
<th>Date of last mammogram</th>
<th>Date of last eye exam</th>
<th>Date of last chest x-ray</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of last Tuberculosis Test</th>
<th>Date of last bone densitometry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Constitutional
- Recent weight gain
  - amount ________________
- Recent weight loss
  - amount ________________
- Fatigue
- Weakness
- Fever
- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

### Eyes–Nose–Mouth–Throat
- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

### Cardiovascular
- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

### Respiratory
- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing (asthma)

### Gastrointestinal
- Nausea
- Vomiting of blood or coffee ground material
- Stomach pain relieved by food or milk
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

### Genitourinary
- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, “smoky” urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

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? ________________

### Musculoskeletal
- Morning stiffness
  - Lasting how long? ____________ Minutes ____________ Hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling
  - List joints affected in the last 6 mos.
    - ________________
    - ________________
    - ________________
    - ________________

### Integumentary (skin and/or breast)
- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

### Neurological System
- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands and/or feet
- Memory loss
- Night sweats

### Psychiatric
- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

### Endocrine
- Excessive thirst

### Hematologic/Lymphatic
- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion/when ________________

### Allergic/Immunologic
- Frequent sneezing
- Increased susceptibility to infection
### SOCIAL HISTORY

Do you drink caffeinated beverages?  

- [ ] Yes  
- [ ] No  

Cups/glasses per day: ____________________________

Do you smoke?  

- [ ] Yes  
- [ ] No  

Past – How long ago? ______

Do you drink alcohol?  

- [ ] Yes  
- [ ] No  

Number per week ______

Has anyone ever told you to cut down on your drinking?  

- [ ] Yes  
- [ ] No  

Do you use drugs for reasons that are not medical?  

- [ ] Yes  
- [ ] No  

If yes, please list: ____________________________________________

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

### PAST MEDICAL HISTORY

Do you now or have you ever had: (check if “yes”)

- [ ] Cancer  
- [ ] Heart problems  
- [ ] Asthma  
- [ ] Goiter  
- [ ] Leukemia  
- [ ] Stroke  
- [ ] Cataracts  
- [ ] Diabetes  
- [ ] Epilepsy  
- [ ] Nervous breakdown  
- [ ] Stomach ulcers  
- [ ] Rheumatic fever  
- [ ] Bad headaches  
- [ ] Jaundice  
- [ ] Colitis  
- [ ] Kidney disease  
- [ ] Pneumonia  
- [ ] Psoriasis  
- [ ] Anemia  
- [ ] HIV/AIDS  
- [ ] High Blood Pressure  
- [ ] Emphysema  
- [ ] Glaucoma  
- [ ] Tuberculosis

Other significant illness (please list) __________________________________________________

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

____________________________________________________

____________________________________________________

____________________________________________________

### Previous Operations

<table>
<thead>
<tr>
<th>Type</th>
<th>Year</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
<td></td>
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<tr>
<td>5.</td>
<td></td>
<td></td>
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<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any previous fractures?  

- [ ] No  
- [ ] Yes  

Describe:

Any other serious injuries?  

- [ ] No  
- [ ] Yes  

Describe:

### FAMILY HISTORY:

<table>
<thead>
<tr>
<th>IF LIVING</th>
<th>IF DECEASED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Age at Death</td>
</tr>
<tr>
<td>Health</td>
<td></td>
</tr>
</tbody>
</table>

Father

Mother

Number of siblings ________ Number living ________ Number deceased ________

Number of children ________ Number living ________ Number deceased ________ List ages of each ________

Health of children: ____________________________________________________________

Do you know of any blood relative who has or had: (check and give relationship)

- [ ] Cancer  
- [ ] Heart disease  
- [ ] Rheumatic fever  
- [ ] Tuberculosis  
- [ ] Leukemia  
- [ ] High blood pressure  
- [ ] Epilepsy  
- [ ] Diabetes  
- [ ] Stroke  
- [ ] Bleeding tendency  
- [ ] Asthma  
- [ ] Goiter  
- [ ] Colitis  
- [ ] Alcoholism  
- [ ] Psoriasis

Patient’s Name ____________________________ Date ____________________________  

Physician Initials ___________________  

Patient History Form © 1999 American College of Rheumatology
**MEDICATIONS**

**Drug allergies:**  □ No  □ Yes  To what? ______________________

Type of reaction:________________________

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Dose (include strength &amp; number of pills per day)</th>
<th>How long have you taken this medication</th>
<th>Please check:</th>
<th>Helped?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>A Lot</td>
<td>Some</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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<tr>
<td>8.</td>
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<tr>
<td>9.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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. Record your comments in the spaces provided.

<table>
<thead>
<tr>
<th>Drug names/Dosage</th>
<th>Length of time</th>
<th>Please check:</th>
<th>Helped?</th>
<th>Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A Lot</td>
<td>Some</td>
<td>Not At All</td>
</tr>
<tr>
<td><strong>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circle any you have taken in the past</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ansaid (flurbiprofen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthrotec (diclofenac + misoprostil)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin (including coated aspirin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celebrex (celecoxib)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinoril (sulindac)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daypro (oxaprozin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disalcid (salsalate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dolobid (diflunisal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feldene (piroxicam)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indocin (indomethacin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lodine (etodolac)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meclofenamate (meclomen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motrin/Rufen (ibuprofen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nalfon (fenoprofen)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Naprosyn (naproxen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oruvail (ketoprofen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolectin (tolmetin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trilisate (choline magnesium trisalicylate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vioxx (rofeccoxib)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voltaren (diclofenac)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pain Relievers**

| Acetaminophen (Tylenol) | |              |         |             |
| Codeine (Vicodin, Tylenol 3) | |              |         |             |
| Propoxyphene (Darvon/Darvocet) | |              |         |             |

Other:

Other:

**Disease Modifying Antirheumatic Drugs (DMARDS)**

| Auranofin, gold pills (Ridaura) | |              |         |             |
| Gold shots (Myochrysine or Solganol) | |              |         |             |
| Hydroxychloroquine (Plaquinil) | |              |         |             |
| Penicillamine (Cuprimine or Depen) | |              |         |             |
| Methotrexate (Rheumatrex) | |              |         |             |
| Azathioprine (Imuran) | |              |         |             |
| Sulfasalazine (Azulfidine) | |              |         |             |
| Quinacrine (Atabrine) | |              |         |             |
| Cyclophosphamide (Cytoxan) | |              |         |             |
| Cyclosporine A (Sandimmune or Neoral) | |              |         |             |
| Etanercept (Enbrel) | |              |         |             |
| Infliximab (Remicade) | |              |         |             |
| Prosorba Column | |              |         |             |

Other:

Other:
### PAST MEDICATIONS Continued

#### Osteoporosis Medications
- **Estrogen (Premarin, etc.)**
- **Alendronate (Fosamax)**
- **Etidronate (Didronel)**
- **Raloxifene (Evista)**
- **Fluoride**
- **Calcitomin injection or nasal (Miacalcin, Calcimar)**
- **Risedronate (Actonel)**
- Other: ____________

#### Gout Medications
- **Probenecid (Benemid)**
- **Colchicine**
- **Allopurinol (Zyloprim/Lopurin)**
- Other: ____________

#### Others
- **Tamoxifen (Nolvadex)**
- **Tiludronate (Skelid)**
- **Cortisone/Prednisone**
- **Hyalgan/Synvisc injections**
- **Herbal or Nutritional Supplements**

Please list supplements:

---

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

If yes, list:

________________________
________________________
________________________
________________________
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No If yes, how many? ____________________________

How many people in household? _______________ Relationship and age of each ________________________________

Who does most of the housework? __________ Who does most of the shopping? __________ Who does most of the yard work? __________

On the scale below, circle a number which best describes your situation; Most of the time, I function...

1 2 3 4 5

VERY POORLY OK WELL VERY

POORLY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)……………………………………. ☐ ☐ ☐

Walking? …………………………………………………………………………………………………………………………. ☐ ☐ ☐

Climbing stairs?………………………………………………………………………………………………………………………. ☐ ☐ ☐

Descending stairs?………………………………………………………………………………………………………………………. ☐ ☐ ☐

Sitting down?………………………………………………………………………………………………………………………. ☐ ☐ ☐

Getting up from chair?………………………………………………………………………………………………………………………. ☐ ☐ ☐

Touching your feet while seated?…………………………………………………………………………………………………. ☐ ☐ ☐

Reaching behind your back?…………………………………………………………………………………………………. ☐ ☐ ☐

Reaching behind your head?…………………………………………………………………………………………………. ☐ ☐ ☐

Dressing yourself?………………………………………………………………………………………………………………………. ☐ ☐ ☐

Getting along with family members?………………………………………………………………………………………. ☐ ☐ ☐

In your sexual relationship?…………………………………………………………………………………………………. ☐ ☐ ☐

Engaging in leisure time activities?………………………………………………………………………………………. ☐ ☐ ☐

With morning stiffness?……………………………………………………………………………………………………………. ☐ ☐ ☐

Do you use a cane, crutches, as walker or a wheelchair? (circle one)…………………………………………………. ☐ ☐ ☐

What is the hardest thing for you to do? ________________________________________________________________

Are you receiving disability?…………………………………………………………………………………………………. ☐ ☐ ☐

Are you applying for disability?……………………………………………………………………………………………….. ☐ ☐ ☐

Do you have a medically related lawsuit pending?…………………………………………………………………………. ☐ ☐ ☐
AMERICAN COLLEGE OF RHEUMATOLOGY

Patient Assessment

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 | Pain as Bad as It Could Be

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 feel – there are no right or wrong answers. Check the one best answer for each question.

**Activity Level**

Right now, are you able to:

1. Dress yourself, including tying shoelaces and doing buttons?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

2. Get in and out of bed?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

3. Lift a full cup or glass to your mouth?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

4. Walk outdoors on flat ground?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

5. Wash and dry your entire body?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

6. Bend down to pick up clothing from the floor?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

7. Turn regular faucets on and off?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

8. Get in and out of a car, bus, train or airplane?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

9. Walk two miles?  
   - Without any difficulty: 0  
   - With some difficulty: 1  
   - With much difficulty: 2  
   - Unable to do: 3

10. Participate in sports and games as you like?  
    - Without any difficulty: 0  
    - With some difficulty: 1  
    - With much difficulty: 2  
    - Unable to do: 3

11. Get a good night’s sleep?  
    - As usual: 0  
    - With some difficulty: 1.1  
    - With much difficulty: 2  
    - Unable to do: 3

12. Deal with feelings of anxiety or being nervous?  
    - As usual: 0  
    - With some difficulty: 1.1  
    - With much difficulty: 2  
    - Unable to do: 3

13. Deal with feelings of depression or feeling blue?  
    - As usual: 0  
    - With some difficulty: 1.1  
    - With much difficulty: 2  
    - Unable to do: 3

Your Name_________________________ Today’s Date___________ Time of Day _______

**Instructions for Office Staff**

Activity Level Index Scoring:  
For FN (questions 1-10) add total points and convert using scale on right. For PS (questions 11-13), add total points.

Visual Analog Scales: measure with metric ruler. Line is exactly 10 cm long. Scores should be recorded in cm.mm format.

Adapted from  