BENCHMARK
Medical Group Inc.

1180 Main St. #7
Windsor CO 80550
970-686-9117
contactus@benchmarkmedicalgroup.com
www.benchmarkmedicalgroup.com

1. Please enter your information.

Whom may we thank for referring you to us?

Date of Birth:

First Name:

Last Name:

Middle Initials:

Gender:
○ Female ○ Male

Address:

Apt./Unit #:

Mobile Phone:

Home Phone:

Work Phone:

Email:

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

2. Emergency Contact:

Phone Number:

Your Occupation:

Employer:

Address:

Apt. / Unit #"

3. Insurance Carrier:

Policy Number:

Group Number:

Policy Holder Name:

Relationship:

Policy Holder DOB:

4. PRIMARY CARE PHYSICIAN INFORMATION

Physician name:

Last Date Seen:

Phone:

Do you have a referral for physical therapy?
○ Yes ○ No

5. PRIMARY CARE PHYSICIAN INFORMATION

Physician name:

Last Date Seen:

Do you have a referral for physical therapy?
○ Yes ○ No

SF36 Health Survey

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by making the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

6. In general, would you say your health is:

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Good
- ○ Fair
- ○ Poor

7. Compared to one year ago, how would you rate your health in general now?

- ○ Much better than one year ago
- ○ Somewhat better now than one year ago
- ○ About the same as one year ago
- ○ Somewhat worse now than one year ago
- ○ Much worse now than one year ago

8. The following questions are about activities you might do during a typical. Does your health now limit you in these activities? If so, how much?

Activities	Limited A Lot	Limited A Little	Not Limited At All
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing several flights of stairs	1	2	3
Climbing one flight of stairs	1	2	3
Bending, kneeling, or stooping	1	2	3
Waling more than a mile	1	2	3
Walking several blocks	1	2	3
Walking one block	1	2	3
bathing or dressing yourself	1	2	3

9. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of you physical health?

	Yes	No
Cut down on the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Were limited in the kind of work or other activities	1	2
Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

10. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities with your work or other regular daily activities as a result of any emotional (e.g. feeling depressed or anxious)?

	Yes	No
Cut down on the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Didn't work or other activities as carefully as usual	1	2

11. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

12. How much physical pain have you had during the past 4 weeks?

- ○ None
- ○ Very mild
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Very Severe

13. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ○ Not at all
- ○ A little bit
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

14. These questions are bout how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

	All of the time	Most of the time	A Good bit of the time	Some of the time	A Little of the time	None of the time
Did you feel full of life?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt downhearted and blue?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you Feel tired	1	2	3	4	5	6

15. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives etc.)

- ○ All of the time
- ○ Most of the time
- ○ Some of the time
- ○ A little bit of the time
- ○ None of the time

16. How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sick a little easier than other people.	1	2	3	4	5
I am as healthy as anybody I know.	1	2	3	4	5
I expect my health to get worse	1	2	3	4	5
My health is excellent.	1	2	3	4	5

17. _____

PRE LAB SCREENING

18.

	Yes	No
Has a doctor ever advised you not to participate in sports or activity due to a heart problem?		
Do you have any heart conditions?		
Are you taking any medications for your heart?		
Have you ever fainted during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pains during or after exercise?		
Do you tire more quickly than your friends during exercise?		
Have you ever been told that you have: a) High Blood Pressure? b) High Cholesterol? c) Heart Infection? d) Heart Murmur? e) Poor Circulation?		
Have you ever had heart tests carried out by a doctor?		
Have you ever had very rapid heart beating that has begun and ended for no apparent reason?		
Has anyone in your family died before the age of fifty from a heart condition for which no cause was found?		
Does anyone in your family have a cardiovascular disease?		
Do you ever feel fatigued or “foggy brained”		
Do you have Osteoporosis or Osteopenia		
Have you ever had problems with your kidneys?		
Do you ever had swelling in your hands or feet?		
Do you have sensation changes in your hands or feet? a) Numbness and/or tingling? b) Cold or feeling “on fire”? c) Feeling like you are walking on rocks? d) Other:		
Do you have Diabetes?		
Does anyone in your family have Diabetes?		
Do you have any additional health concerns?		

If other, please specify:

19. Explain any 'YES' Answers:

Patient Signature:

Signature Date

Reviewed by Signature:

Signature Date