



New Problem Questionnaire

Please check a box as appropriate

Name: _____ Age: _____ Date: _____

1) Sex: Male or Female

2) Are you Right or Left Handed?

3) Approximate Height: _____ feet _____ inches and Weight: _____ lbs

4) Where is your main problem? _____

5) What is your main problem?

Pain

Unstable or Dislocating Joint

Numbness

Swelling

Weakness

Stiffness

Other(explain): _____

6) How did your problem start? (give details as needed)

Job Injury

Sports Injury

Motor Vehicle Accident

Gradual or Slow Onset

Other (explain): _____

7) How long have you had this problem, approximately? _____

8) Is your problem:

Improving

Worsening

Staying the Same

9) Does your pain or problem awaken you from sleep?

Yes No

10) Is your pain or problem intermittent? Yes No or Constant? Yes No

11) What worsens your problem? (give details as needed)

Exercise

Repetitive Motions

Nothing

Sitting

Overhead Activities

Rest

Standing

Coughing, Sneezing, Straining

Walking

Other (explain): _____

12) What helps your problem? Rest Nothing Other(explain): _____

13) Are regular activities or walking limited because of your problem? Yes No

14) Do you use any assistive devices? Cane Walker Wheelchair Other: _____

14) Have you had this problem before now? No Yes When? _____

15) Have you had previous medical treatment for this? (give details and general dates)

None

Emergency room: _____

Physical Therapy

Injection

Physician: _____

Surgery: _____

Other: _____

16) What tests have you had?

X-rays

Nerve Test (EMG or NCV)

CT Scan or MRI

Ultrasound

Other: _____

17) What medicines are you taking specifically for this problem? _____

18) Are you on or applying to any of the following programs because of your problem?

Disability

Worker's Compensation

(Please complete form on reverse side)

19) What is your occupation? _____

20) What is your present work status?

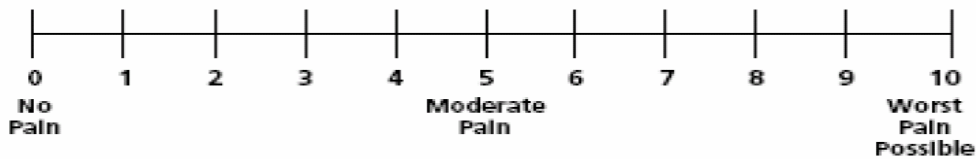
- Not Working Date last worked: _____
- Light Duty For how long? _____
- Regular Duty, no restrictions

21) If you are working, does your job require the following?

- Lifting How Many Pounds: _____
- Frequent Bending & Lifting
- Frequent Squatting or Kneeling
- Climbing
- Extended Walking
- Continuous Standing
- Sitting
- Repetitive Motions

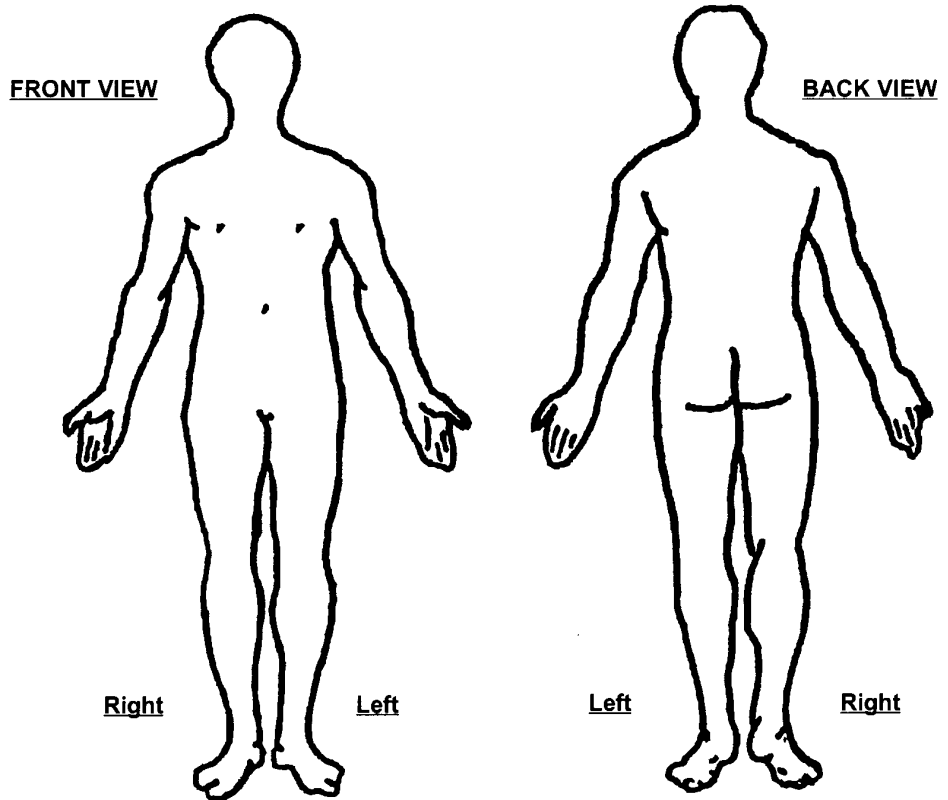
22) Are there any other acute problems in your life right now or anything else regarding your problem that you wish us to know? _____

23) Please make a mark on the scale regarding the severity of your problem.



24) Mark the area(s) on your body where you feel the sensations described below, using the appropriate symbol. Include all pertinent areas and radiating pain.

- *Ache* / *Sharp Pain* Δ *Burning or Tingling* # *Numbness*



To complete the picture, draw in your face and place an "X" where the pain is worst now

X _____
Signature of Patient, Parent, or Guardian

_____ Date

X _____
Reviewed by MD