Bone & Joint Clinic

New Problem Questionnaire

(Please Print)

Patient Name ______________________________ Date _________

Age ________ □ M □ F Occupation ________________________

Dominant Hand □ R □ L Height ________ Weight ________

Who is your Primary Care Physician? ______________________

Who referred you here? ________________ □Doctor □Family/Friend □Self □Attorney □Other

1. What is your chief complaint (main reason for visit)?

□Pain □Stiffness □Unstable/Dislocating Joint

□Numbness □Swelling □Other______________

□Weakness □Fracture/Broken Bone

2a. Location: What **body part** is involved? ______________________________

b. Left or Right? ____

3. Duration: How long has this problem been present? ______________________

4. How did the problem start? □gradual □sudden
(Please select one of the following.)

A. No injury
   Why do you think the problem started? ______________________
B. Injury at work (Date_________)
   From a □lift □twist □bend □pull □reach □other______________
C. Work related
   How did your job cause this problem? ______________________
D. Sports injury (Date_________) What sport? ____________
   Please explain ____________________________________
E. Auto accident (Date _________)
   Please describe the accident ______________________
   □driver □passenger • seatbelt? □yes □no • airbag? □yes □no
F Other (e.g. fall, direct blow, etc.)
   Please explain ____________________________________

5. What is the level of pain? □none □mild □moderate □severe

6. Please describe the quality of pain. □sharp □dull □throbbing □aching □burning □other ________

7. Since this problem started, it is: □improving □worsening □unchanged

8. Does your pain awaken you from sleep? □yes □no

9. Is your pain: □constant □intermittent (comes and goes)

10. Do you have: □swelling □bruising □numbness □tingling □weakness □bladder or bowel dysfunction □giving out □stiffness □locking □popping/clicking

11. What worsens the problem? □nothing □standing □walking □running □stairs □exercise □squatting □kneeling □lifting □twisting □bending □lying in bed □sitting □coughing □sneezing □throwing □overhead activity □grabbing □repetitive motion (explain,___________) □other ________

12. What helps the problem? □rest □heat □ice □elevation □brace/splint □medicine □nothing □other ___________

13. Please list medications taken specifically for this problem. ____________________

14. Have you had this same problem previously? □no □yes When? ___________

15. What previous treatment has been tried? (please provide any detail and dates)

□none	□injection ______________
□bracing	□previous medicine ____________
□physical therapy ___________	□crutches
□surgery _____________	□cane
□chiropractic ____________	□other ____________

16. Were you seen in the ER or after hour clinic for this problem?
□no □yes Where ____________ Date _______

17. What tests have you had for this problem?
□none □Xray □MRI □CT scan □nerve test (EMG/NCV) □bone scan □ultrasound □other ______________

Office use only

________f/u	________DME	________PT	________MRI/CT	________work stat
________med	________cast/splnt	________HEP	________Surg	________c/s
________inj	________ice	________EMG/NCS	________other	