



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?

<input type="checkbox"/> Pain	<input type="checkbox"/> Unstable or Dislocating Joint
<input type="checkbox"/> Numbness	<input type="checkbox"/> Swelling
<input type="checkbox"/> Weakness	<input type="checkbox"/> Stiffness
<input type="checkbox"/> Other(explain): _____	
- 6) How did your problem start? (give details as needed)

<input type="checkbox"/> Job Injury	<input type="checkbox"/> Sports Injury
<input type="checkbox"/> Motor Vehicle Accident	<input type="checkbox"/> Gradual or Slow Onset
<input type="checkbox"/> Other (explain): _____	
- 7) How long have you had this problem, approximately? _____
- 8) Is your problem:

<input type="checkbox"/> Improving	<input type="checkbox"/> Worsening	<input type="checkbox"/> Staying the Same
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- 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)

<input type="checkbox"/> Exercise	<input type="checkbox"/> Repetitive Motions	<input type="checkbox"/> Nothing
<input type="checkbox"/> Sitting	<input type="checkbox"/> Overhead Activities	<input type="checkbox"/> Rest
<input type="checkbox"/> Standing	<input type="checkbox"/> Coughing, Sneezing, Straining	<input type="checkbox"/> Walking
<input type="checkbox"/> 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)

<input type="checkbox"/> None	<input type="checkbox"/> Emergency room: _____
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Injection
<input type="checkbox"/> Physician: _____	
<input type="checkbox"/> Surgery: _____	
<input type="checkbox"/> Other: _____	
- 16) What tests have you had?

<input type="checkbox"/> X-rays	<input type="checkbox"/> Nerve Test (EMG or NCV)
<input type="checkbox"/> CT Scan or MRI	<input type="checkbox"/> Ultrasound <input type="checkbox"/> 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?

<input type="checkbox"/> Disability	<input type="checkbox"/> Worker's Compensation
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(Please complete form on reverse side)

19) What is your occupation? _____

20) What is your present work status?

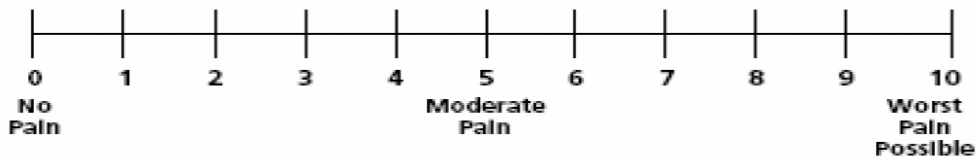
- Not Working Date last worked: _____
- Light Duty For how long? _____
- Regular Duty, no restrictions

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

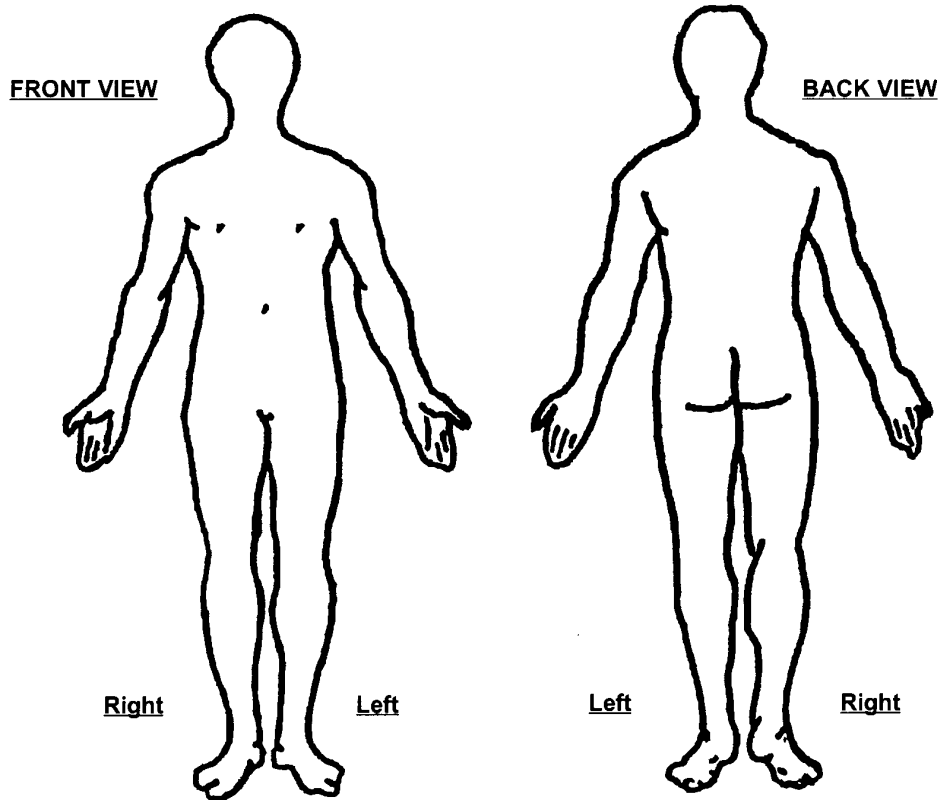
22) Are there any other acute problems in your life right now or anything else regarding your problem that you wish us to know? _____

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 _____ Date X _____
Signature of Patient, Parent, or Guardian Reviewed by MD