

# New Problem Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Primary Physician: \_\_\_\_\_  
name clinic address phone

Referring Physician: \_\_\_\_\_  
name clinic address phone

Age: \_\_\_\_\_ (circle one) Left / Right Handed (circle one) Female / Male

Where is your main problem? \_\_\_\_\_

What is your main problem you want the doctor to treat today? (please check all that apply)

- Pain  Numbness  Swelling  Weakness  Stiffness  Unstable Joint  Wound  
Other (please describe) \_\_\_\_\_

When did your problem begin? Please give the approximate date. \_\_\_\_\_

Briefly describe how your problem started: \_\_\_\_\_

- Job Injury  Car Accident  Sports Injury  Suddenly  Gradually

The problem is:  constant or  intermittent

Does your problem awaken you from sleep?  yes  no

The problem is:  getting better  getting worse  staying the same

What worsens the problem?

- Exercise  Repetitive Motions  Bending  
 Sitting  Overhead Activities  Stairclimbing  
 Standing  Coughing, Sneezing, Straining  Nothing  
 Walking  Rest  Other \_\_\_\_\_

What helps the problem?

- Rest  Ice  Heat  Medication  Nothing  Other: \_\_\_\_\_

Are any of the following activities limited because of your problem?

- Dressing  Bathing  Toileting  Feeding  Getting up from a bed or chair

For this problem, what tests or treatments have you had and did they help?

ER \_\_\_\_\_ Physical Therapy \_\_\_\_\_ Nerve Test \_\_\_\_\_  
Physician \_\_\_\_\_ X-Rays \_\_\_\_\_ UltraSound \_\_\_\_\_  
Surgery \_\_\_\_\_ CT Scan \_\_\_\_\_ Chronic Pain Mgmt \_\_\_\_\_  
Injection \_\_\_\_\_ MRI \_\_\_\_\_ Other \_\_\_\_\_  
Medications \_\_\_\_\_

Are You Employed  yes  no What is your occupation? \_\_\_\_\_

Work Status

- Regular Duty  
 Light Duty - on what date did you start light duty as a result of your new problem? \_\_\_\_\_  
 Not working - on what date did you last work as a result of your new problem? \_\_\_\_\_  
 Retired  
 Other \_\_\_\_\_

## New Problem Questionnaire

**If you are working, does your job require the following?** (please check all that apply)

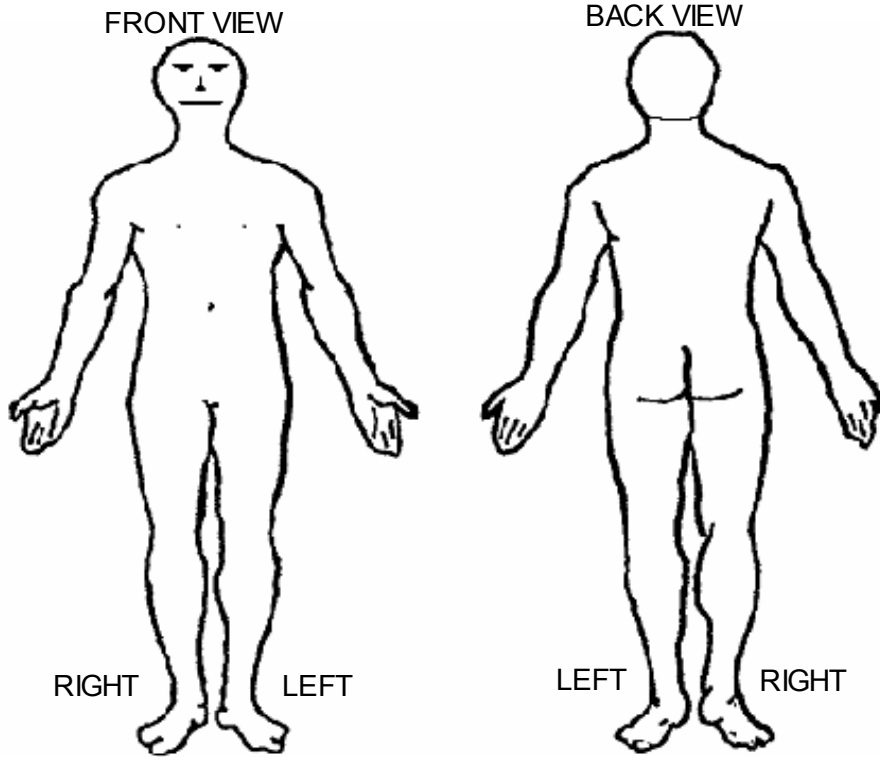
- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Lifting 0 - 10 lbs  | <input type="checkbox"/> Frequent Lifting  | <input type="checkbox"/> Climbing            | <input type="checkbox"/> Repetitive hand motions |
| <input type="checkbox"/> Lifting 11 - 20 lbs | <input type="checkbox"/> Frequent Sitting  | <input type="checkbox"/> Extended Walking    | <input type="checkbox"/> Repetitive arm motions  |
| <input type="checkbox"/> Lifting 21 - 50lbs  | <input type="checkbox"/> Frequent Kneeling | <input type="checkbox"/> Continuous Standing |  |
| <input type="checkbox"/> Lifting over 50 lbs | <input type="checkbox"/> Frequent Bending  | <input type="checkbox"/> Sitting             |  |

**Are you planning to apply to any of the following programs because of your problem?**

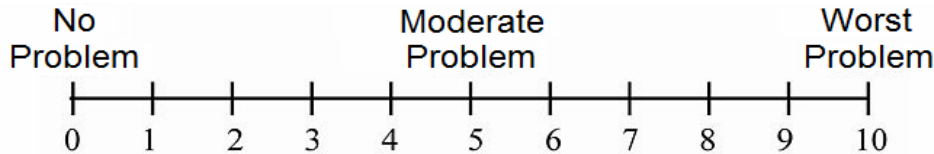
- |               |                              |                             |                          |                              |                             |
|---------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| A. Disability | <input type="checkbox"/> yes | <input type="checkbox"/> no | B. Worker's Compensation | <input type="checkbox"/> yes | <input type="checkbox"/> no |
|---------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|

**Mark where your problem is located using the symbols below. Place an "X" at the worst spot.**

Aching △△△	Numbness ===	Pins & Needles OOO	Burning □□□	Stabbing ///
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**Please mark how bad your problem is now:**



**Are there any other acute problems or crises in your life now?**  Yes  No

**If yes, please explain:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_