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 _____

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

- □ Lifting 0 - 10 lbs
- □ Lifting 11 - 20 lbs
- □ Lifting 21 - 50lbs
- □ Lifting over 50 lbs
- □ Frequent Lifting
- □ Frequent Sitting
- □ Frequent Kneeling
- □ Frequent Bending
- □ Climbing
- □ Extended Walking
- □ Continuous Standing
- □ Sitting
- □ Repetitive hand motions
- □ Repetitive arm motions

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

A. Disability □ yes □ no B. Worker's Compensation □ yes □ no

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

Aching	Numbness	Pins & Needles	Burning	Stabbing
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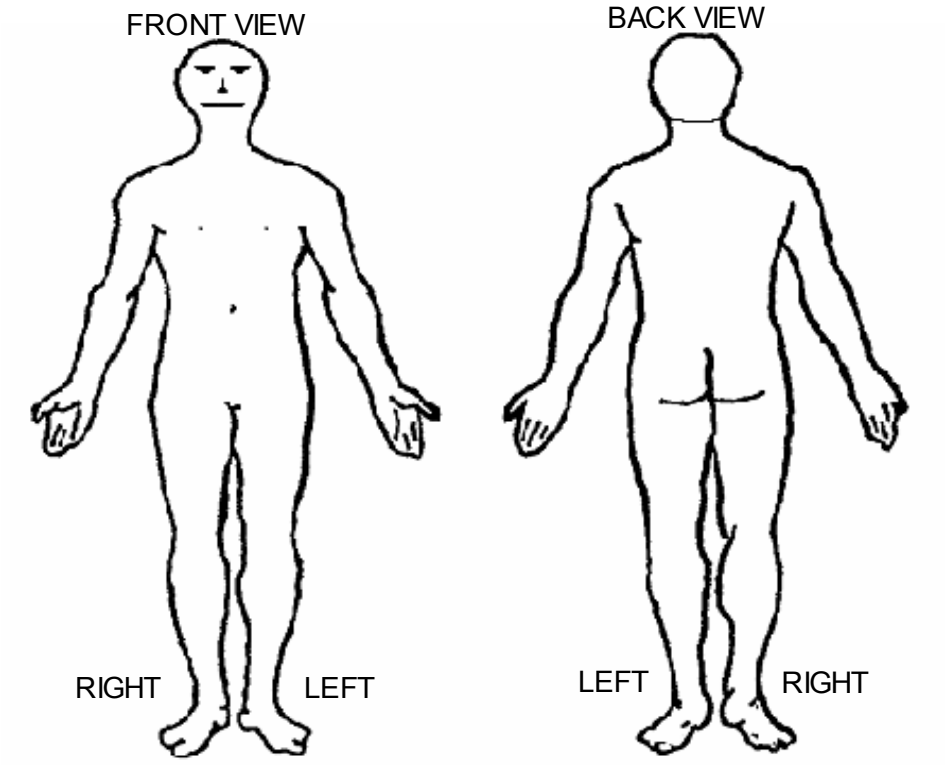
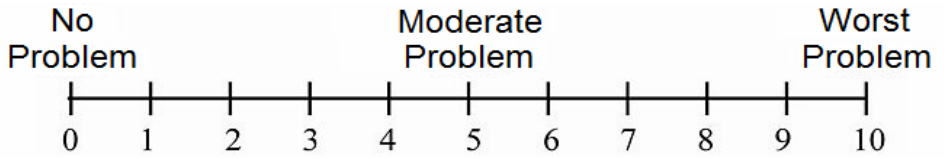


Please mark how bad your problem is now:



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

If yes, please explain: _____

Patient Signature: _____ **Date:** _____