New Problem Questionnaire

Please Check a box as appropriate

Name:____ Age: _______Date:____________

1) Sex: □ Male or □ Female Height ________________ Weight _________________

2) Are you □ Right or □ Left-Handed?

3) What brings you in today? ____

____

____

4) What is your main problem?

□ Pain □ Unstable or Dislocating Joint
□ Numbness □ Swelling
□ Weakness □ Stiffness
□ Other (explain):____

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

□ Job Injury □ Sports Injury
□ Motor Vehicle Accident □ Gradual or Slow Onset
□ Other (explain):____

6) How long have you had this problem, approximately? _______________________________

7) Is your pain: □ Aching □ Burning □ Dull □ Piercing □ Sharp □ Throbbing

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 □ Going up and down stairs □ Walking
□ Other (explain):____

12) What helps your problem? □ Brace □ Elevation □ Heat □ Ice □ Injection
□ Massage □ Pain meds □ NSAIDs □ Physical therapy □ Rest □ Stretching □ Nothing
Other (explain):____________________

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

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

15) What tests have you had?

□ X-rays □ Nerve Test (EMG or NCV)
□ CT Scan or MRI □ Ultrasound □ Other:_______________

17) What medicines are you taking for this problem?__________________________________

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

□ Disability □ Worker's Compensation

19) What is your occupation?____

20) What is your present work status?

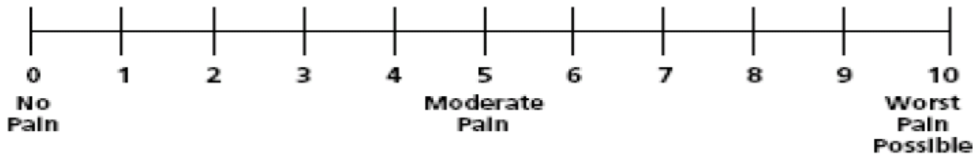
☐ Not Working Date last worked: ___________________________
☐ Light Duty For how long? ______________________________
☐ Regular Duty, no restrictions

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

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

22) Any other acute problems in your life right now or anything else regarding your problem that you wish us to know?____

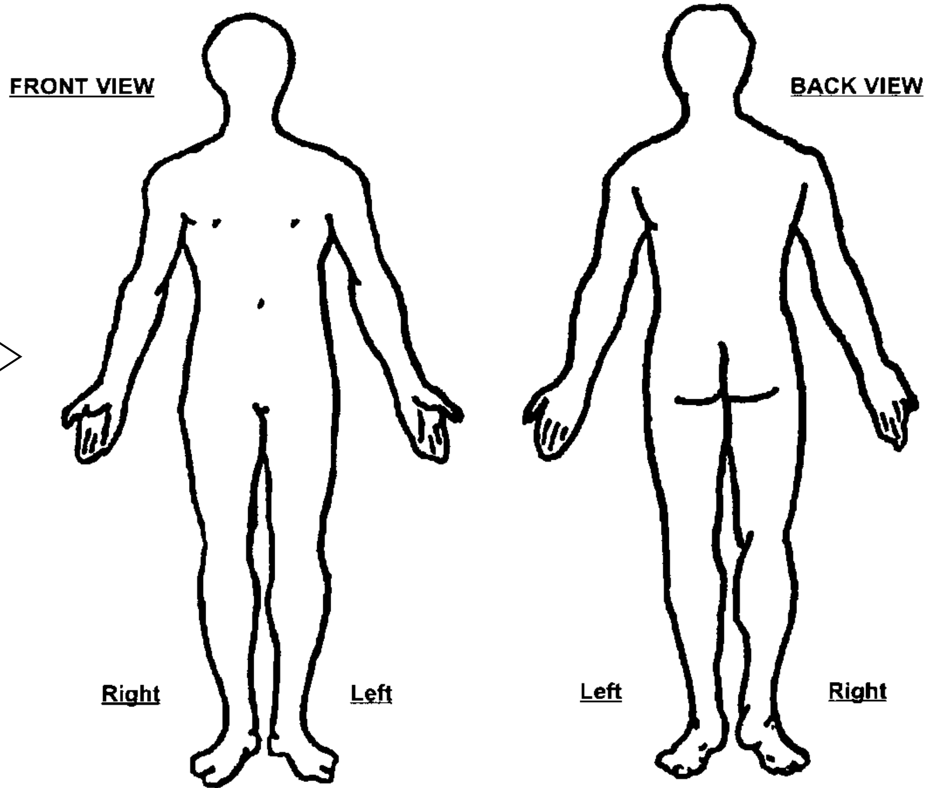
23) Please make a mark on the scale regarding the severity of your problem.



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____ _____________ X________________________

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