

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)

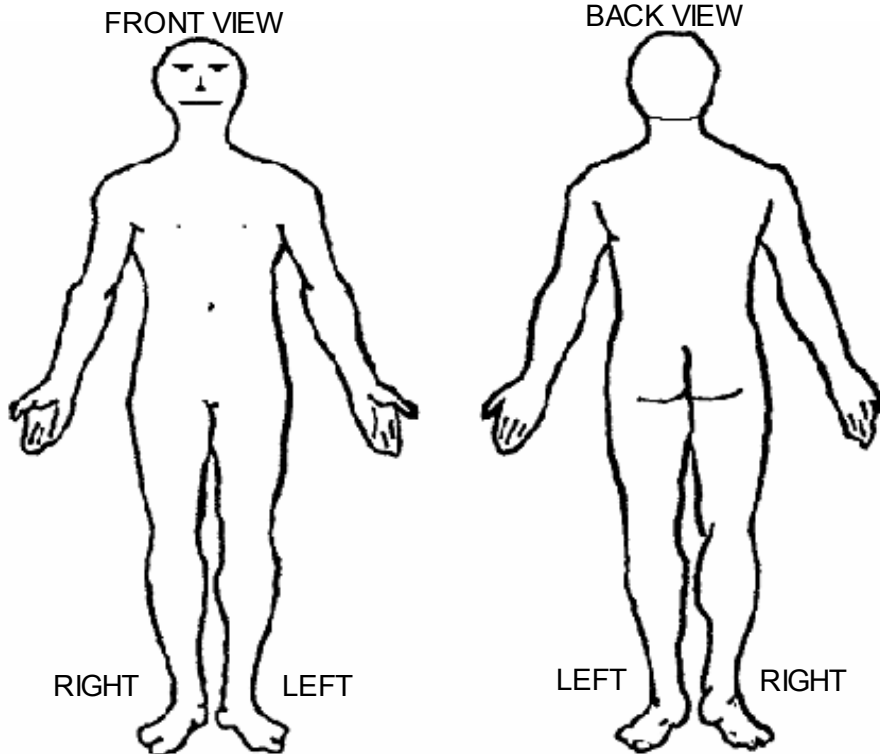
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Lifting 0 - 10 lbs | <input type="checkbox"/> Frequent Lifting | <input type="checkbox"/> Climbing | <input type="checkbox"/> Repetitive hand motions |
| <input type="checkbox"/> Lifting 11 - 20 lbs | <input type="checkbox"/> Frequent Sitting | <input 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?

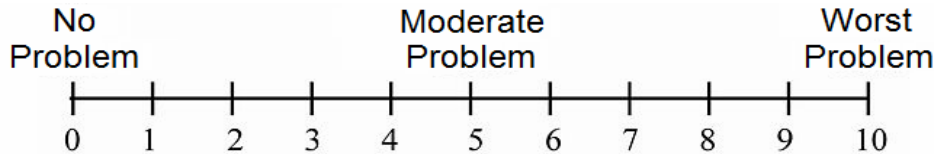
- | | | | | | |
|---------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| A. Disability | <input type="checkbox"/> yes | <input type="checkbox"/> no | B. Worker's Compensation | <input type="checkbox"/>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