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## PATIENT PROBLEM QUESTIONNAIRE

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

*Please specify - R for Right L for Left B for Both*

1. What part of the body are you being seen for today?
 

<input type="checkbox"/> Shoulder	<input type="checkbox"/> Elbow	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand
<input type="checkbox"/> Hip	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot
<input type="checkbox"/> Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Other: _____	
  
2. Is your problem the result of an injury?  Yes  No (If "No", then proceed with question #7.)
  
3. What was the date of your injury? \_\_\_\_\_ Time of injury: \_\_\_\_\_ A.M. / \_\_\_\_\_ P.M.
  
4. How were you injured?
 

<input type="checkbox"/> Sports - please specify the sport: _____
<input type="checkbox"/> Car accident <input type="checkbox"/> Motorcycle accident <input type="checkbox"/> A fall
  
5. Where were you injured?  Work  School  Home  Other: \_\_\_\_\_
  
6. How did injury occur? \_\_\_\_\_
  
7. How long have you had this problem? (*Please specify a number.*)  Days  Wks.  Months  Years
  
8. How would you describe the pain that you are experiencing? (*Please check all which apply.*)
 

Quality:  Sharp  Dull  Throbbing

Severity:  Mild  Moderate  Severe

Duration:  Lasts for minutes  Lasts for hours  Constant

Timing:  Pain with exercise or activity  Pain at rest  Pain at nighttime

Context:  Pain is getting worse  Pain is staying the same  Pain keeps recurring

Modifying factors:  Better with rest  Better with ice  Better with limb elevation

Associated symptoms:  Numbness  Tingling  Limb feels cold
  
9. What types of treatment have you had for this problem?
 

<input type="checkbox"/> Anti-inflammatory medications	<input type="checkbox"/> Surgery
<input type="checkbox"/> Cortisone injections	<input type="checkbox"/> No treatment
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Other: _____
  
10. How were you referred to us?
 

<input type="checkbox"/> Advertisement	<input type="checkbox"/> Health Fair	<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/> Other _____
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> High School	<input type="checkbox"/> Website	
  
11. Who is your Primary Care Physician: \_\_\_\_\_
  
12. Are you right or left handed? \_\_\_\_\_

**Office Use Only**

Weight \_\_\_\_\_ Height \_\_\_\_\_  
B/P \_\_\_\_\_ H/R \_\_\_\_\_