PONTCHARTRAIN

Bone & Joint Clinic

New Problem Questionnaire

(Please Print)

Patient Name _____ Date _____

Age _____ □ M □ F Occupation _____

Dominant Hand □ R □ L Height _____ Weight _____

Who is your Primary Care Physician? _____

Who referred you here? _____ □Doctor □Family/Friend □Self □Attorney □Other

1. What is your chief complaint (main reason for visit)?

□Pain □Stiffness □Unstable/Dislocating Joint

□Numbness □Swelling □Other_____

□Weakness □Fracture/Broken Bone

2a. Location: What **body part** is involved? _____

b. Left or Right? _____

3. Duration: How long has this problem been present? _____

4. How did the problem start? □gradual □sudden
(Please select one of the following.)

A. No injury
Why do you think the problem started? _____

B. Injury at work (Date_____)
From a □lift □twist □bend □pull □reach □other_____

C. Work related
How did your job cause this problem? _____

D. Sports injury (Date_____) What sport? _____
Please explain _____

E. Auto accident (Date _____)
Please describe the accident _____
□driver □passenger • seatbelt? □yes □no • airbag? □yes □no

F Other (e.g. fall, direct blow, etc.)
Please explain _____

5. What is the level of pain? □none □mild □moderate □severe

6. Please describe the quality of pain. □sharp □dull □throbbing □aching □burning
□other _____

7. Since this problem started, it is: □improving □worsening □unchanged

8. Does your pain awaken you from sleep? □yes □no

9. Is your pain: □constant □intermittent (comes and goes)

10. Do you have: □swelling □bruising □numbness □tingling □weakness
□bladder or bowel dysfunction □giving out □stiffness
□locking □popping/clicking

11. What worsens the problem? □nothing □standing □walking □running □stairs
□exercise □squatting □kneeling □lifting □twisting
□bending □lying in bed □sitting □coughing □sneezing
□throwing □overhead activity □grabbing
□repetitive motion (explain,_____) □other _____

12. What helps the problem? □rest □heat □ice □elevation □brace/splint □medicine
□nothing □other _____

13. Please list medications taken specifically for this problem. _____

14. Have you had this same problem previously? □no □yes When? _____

15. What previous treatment has been tried? (please provide any detail and dates)

□none
□bracing
□physical therapy _____
□surgery _____
□chiropractic _____
□injection _____
□previous medicine _____
□crutches
□cane
□other _____

16. Were you seen in the ER or after hour clinic for this problem?
□no □yes Where _____ Date _____

17. What tests have you had for this problem?
□none □Xray □MRI □CT scan □nerve test (EMG/NCV) □bone scan □ultrasound
□other _____

Office use only

_____f/u	_____DME	_____PT	_____MRI/CT	_____work stat
_____med	_____cast/splnt	_____HEP	_____Surg	_____c/s
_____inj	_____ice	_____EMG/NCS	_____other	