ANIMAS ORTHOPEDIC ASSOCIATES and SPORTS MEDICINE
an office sharing agreement

New Problem Questionnaire

Please Check a box as appropriate

Name:_____ Age: _____Date:_____

1) Sex: □ Male or □ Female

2) Are you □ Right or □ Left Handed?

3) Approximate Height: _____ feet _____ inches and Weight: _____lbs

4) Where is your main problem?_____

5) What is your main problem?

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

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

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

7) How long have you had this problem, approximately?_____

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 □ Coughing, Sneezing, Straining □ Walking
□ Other (explain):_____

12) What helps your problem? □ Rest □ 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:_____

14) Have you had this problem before now? □ No □ Yes When?_____

15) Have you had previous medical treatment for this? (give details and general dates)

□ None
□ Emergency room:_____
□ Physical Therapy
□ Injection
□ Physician:_____
□ Surgery:_____
□ Other:_____

16) 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?

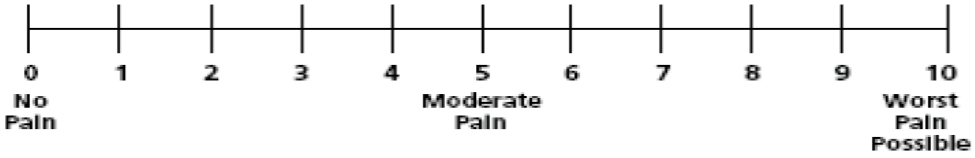
- □ Not Working Date last worked:_____
- □ Light Duty For how long?_____
- □ Regular Duty, no restrictions

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

- □ Lifting How Many Pounds:_____
- □ Frequent Bending & Lifting
- □ Frequent Squatting or Kneeling
- □ Climbing
- □ Extended Walking
- □ Continuous Standing
- □ Sitting
- □ Repetitive Motions

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

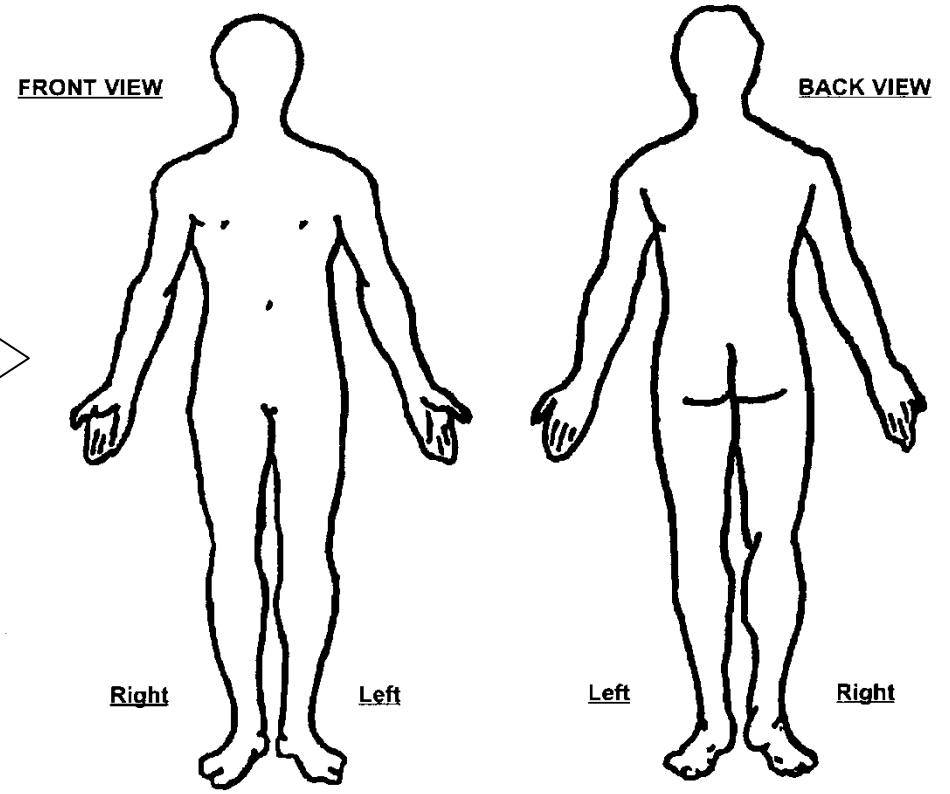
23) Please make a mark on the scale regarding the severity of your problem.



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