NEW PATIENT/NEW PROBLEM QUESTIONNAIRE

DATE: ***NAME:*** ***AGE:*** ***DOB:***

☐RT. OR ☐LT. ***HANDED***

PROBLEM: _____

DATE SYMPTOMS STARTED: _____ ***OR*** ☐ ___MONTHS AGO ☐ ___YEARS AGO

INJURY: ☐ NO ☐ YES (DESCRIBE) _____

DID YOUR PROBLEM OCCUR AT WORK? ☐ NO ☐ YES ***MOTOR VEHICLE?*** ☐ NO ☐ YES

PREVIOUS PROBLEM IN THIS AREA? ☐ NO ☐ YES (DESCRIBE) _____

PAIN DEGREE: ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

PAIN OCCURRENCE: ☐ CONSTANT ☐ FREQUENT ☐ OCCASIONAL
☐ WITH ACTIVITY ☐ AT REST ☐ RANDOM

NUMBNESS OR TINGLING: ☐ NO ☐ YES (LOCATION) _____

WEAKNESS: ☐ NO ☐ YES (LOCATION) _____

STATUS PRIOR TO PROBLEM? ☐STUDENT ☐WORKING ☐HOMEMAKER ☐RETIRED FROM _____

OCCUPATION: _____ **DESCRIBE PHYSICAL REQUIREMENTS:** _____

PRIOR ACTIVITY LEVEL: ☐ SEDENTARY ☐ LIGHT ☐MODERATE ☐ HEAVY

DESCRIBE: _____

ACTIVITY LEVEL SINCE PROBLEM: WORKING? ☐ NO ☐ YES ☐LIGHT DUTY

DESCRIBE: _____

CURRENT EXERCISE ABILITY: ☐ SEDENTARY ☐ LIGHT ☐ MODERATE ☐ HEAVY

DESCRIBE: _____

HAVE YOU HAD (CIRCLE) X-RAYS-MRI-NERVE TESTING-SCAN FOR THIS PROBLEM? ☐ NO ☐ YES
WHEN & WHERE: _____

TREATMENT SO FAR FOR THIS PROBLEM: ☐ NONE

MEDICATIONS: ☐ NO ☐ YES (DESCRIBE) _____
DID IT HELP? ☐ NO ☐ YES ☐ TEMPORARILY/ HOW LONG? _____

ACTIVITY/JOB MODIFICATION: ☐ NO ☐ YES (DESCRIBE) _____
DID IT HELP? ☐ NO ☐ YES

PHYSICAL THERAPY: ☐ NO ☐ YES (DESCRIBE) _____
DID IT HELP? ☐ NO ☐ YES

INJECTIONS: ☐ NO ☐ YES (DESCRIBE) _____
DID IT HELP? ☐ NO ☐ YES

SURGERY: ☐ NO ☐ YES (DESCRIBE) _____
DID IT HELP? ☐ NO ☐ YES ☐ TEMPORARILY/HOW LONG? _____

COMMENTS: _____

_____

_____