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: ____

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□ 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 ____

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If you are working, does your job require the following? (please check all that apply)

☐ Lifting 0 - 10 lbs	☐ Frequent Lifting	☐ Climbing	☐ Repetitive hand motions
☐ Lifting 11 - 20 lbs	☐ Frequent Sitting	☐ Extended Walking	☐ Repetitive arm motions
☐ Lifting 21 - 50lbs	☐ Frequent Kneeling	☐ Continuous Standing	
☐ Lifting over 50 lbs	☐ Frequent Bending	☐ Sitting	

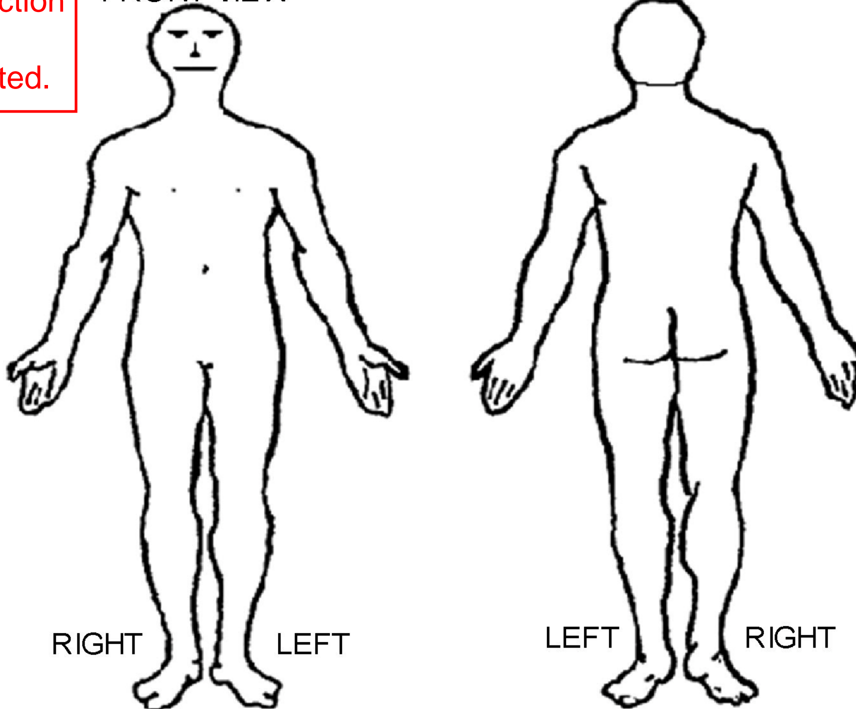
Are you planning to apply to any of the following programs because of your problem?

A. Disability ☐ yes ☐ no   B. Worker's Compensation ☐ yes ☐ no

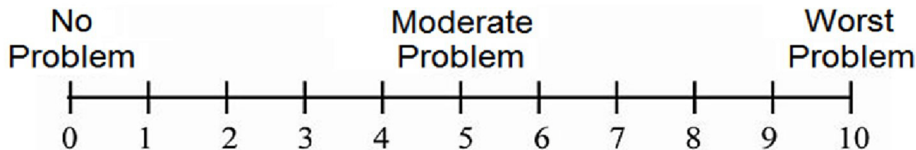
Mark where your problem is located using the symbols below. Place an "X" at the worst spot.

Aching	Numbness	Pins & Needles	Burning	Stabbing
ΔΔΔ	= = =	OOO	□□□	///

Please note: This section of the forms must be printed to be completed.



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:** ________________