

NEW PATIENT QUESTIONNAIRE

Name _____ Date _____

1. What are your specific problems/chief complaints? Please list in order of importance.
A)
B)
C)
D)

2. What was the approximate date you first noticed these symptoms?

3. What was the cause of these symptoms? If sports injury or trauma, please describe.

4. Are you out of school due to your injuries? YES NO Since ___/___/___

5. Have you had similar injuries in the past? YES NO When _____

6. Do you participate in any organized activities (sports, dance, band)?

7. If so, are you currently able to perform these activities? Please describe.

8. How often does your pain occur?

___ one or more days per month ___ one or more days per week

___ daily but intermittent ___ continuous

9. How intense is your pain?

___ absent to mild ___ more than mild but tolerable ___ moderately severe

___ severe ___ intolerable or worst ever experienced

10. Please rate your pain from 1-10. (1=no pain; 10= emergency room pain)

1 2 3 4 5 6 7 8 9 10

What activities, positions, or treatments improve your symptoms?

What activities, positions, or treatments worsen your symptoms?

11. Are your symptoms ___ improving ___ worsening ___ staying the same?

12. Have your symptoms changed in type since onset? If yes, please explain.

13. Are you wearing any type of brace or support for your injury?

Name _____ Date _____

14. Please list any medications you are taking and the dosage and frequency of each.

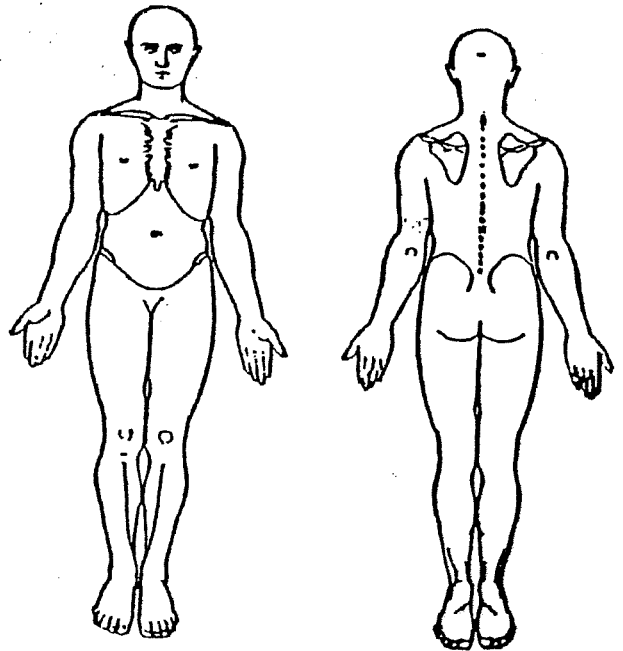
15. Please list all surgeries you have had in the past with the approximate date and surgeon who performed it.

16. Please list all healthcare providers you have seen for this or related conditions, including your primary care physician.

17. Please list any x-rays, MRIs, CT scans, or other special tests you have had.

18. Are you allergic to any medications?

Please mark the areas that you have pain.
Place an "X" on specific spots of pain and
Shade areas of general pain.



Patient or Guardian Signature