



New Problem Questionnaire

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____

Please circle the appropriate numbers.

1. **Where is your main problem?** _____
2. **What is your main problem?**

1 Pain	5 Unstable or Dislocating Joint
2 Numbness	6 Swelling
3 Weakness	7 Other (explain): _____
4 Stiffness	
3. **How did your problem start? (give details as needed)**

1 Job Injury	4 Suddenly
2 Car Accident	5 Gradually
3 Sports Injury	6 Other (explain): _____
4. **How long have you had this problem, approximately?** _____
(give # of days, weeks, months or years)
5. **Is your problem:**

1 Improving	2 Worsening	3 Staying the Same
-------------	-------------	--------------------
6. **Does your pain or problem awaken you from sleep?** 1 Yes 2 No
7. **Is your pain or problem intermittent?** 1 Yes 2 No **constant?** 1 Yes 2 No
8. **What worsens your problem? (give details as needed)**

1 Exercise	5 Repetitive Motions	9 Nothing
2 Sitting	6 Overhead Activities	10 Other: _____
3 Standing	7 Coughing, Sneezing, Straining	
4 Walking	8 Rest	
9. **What helps your problem?** 1 Rest 2 Nothing 3 Other (give details) _____
10. **Are your regular activities limited specifically because of your problem?** _____
11. **Have you had this problem before now?** 1 No 2 Yes When? _____ For how long _____
12. **Have you had previous medical treatment for this? (give details and general dates)**

1 None	5 Injection _____
2 Yes	6 Physical Therapy _____
3 Emergency room _____	7 Surgery _____
4 Physician _____	8 Other: _____
13. **What tests have you had?**

1 X-rays	4 Nerve Test (EMG)
2 CT Scan	5 Ultrasound
3 MRI	6 Other: _____
14. **What medicines are you taking specifically for this problem?** _____
15. **Are you on or planning to apply to any of the following programs because of your problem?**

A. Disability 1 Yes 2 No	B. Worker's Compensation 1 Yes 2 No
---------------------------------	--
16. **What is your occupation?** _____
17. **What is your present work status?**

1. Not Working	Date last worked: _____
2. Light Duty	For how long? _____
3. Regular Job	

(please go to next page)

18. If you are working, does your job require the following?

- | | | |
|-------------------------------|----------------------------------|---------------------------------------|
| 1 Very Little Lifting (0-10#) | 6 Frequent Squatting or Kneeling | 11 Repetitive motions w/hands or arms |
| 2 Light Lifting (11-20#) | 7 Climbing | 12 Repetitive motions w/feet or legs |
| 3 Medium Lifting (21-50#) | 8 Extended Walking | |
| 4 Heavy Lifting (over 50#) | 9 Continuous Standing | |
| 5 Frequent Bending & Lifting | 10 Sitting | |

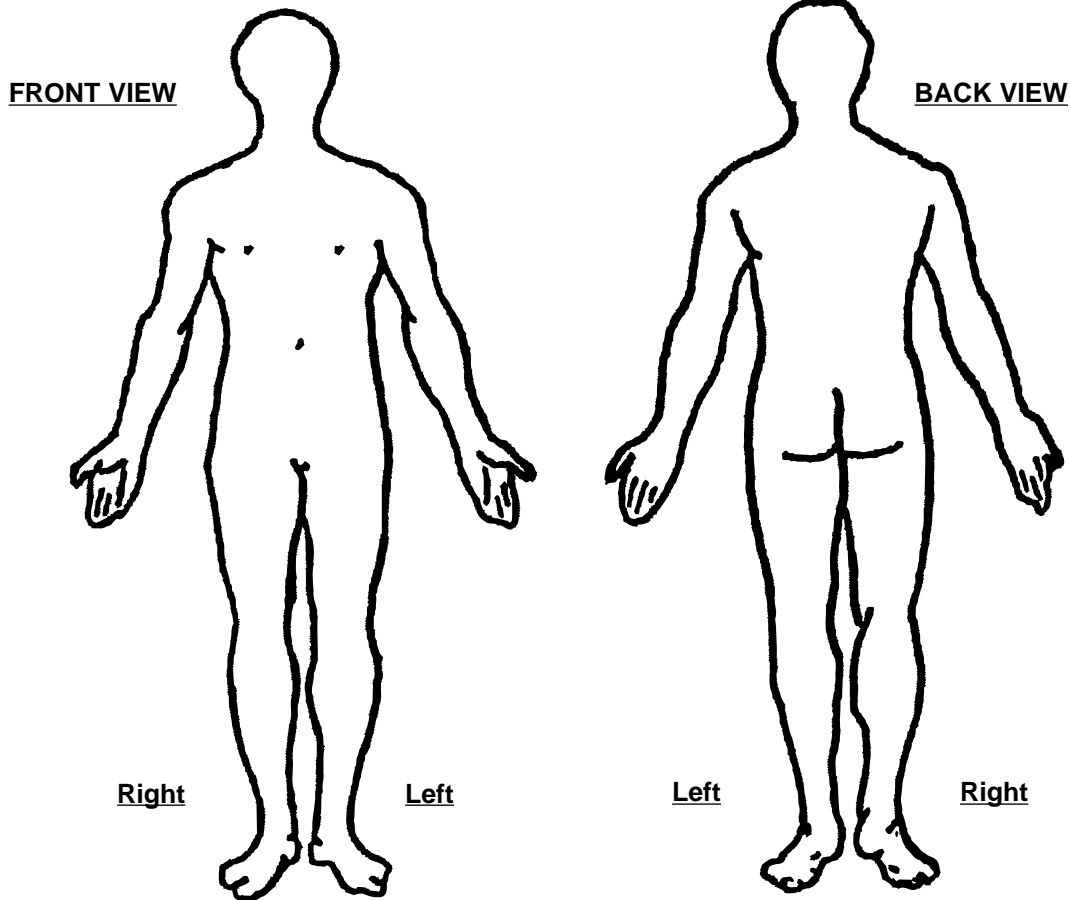
19. Please mark the appropriate box showing how bad your pain or problem is now.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
No Problem	10	20	30	40	50	60	70	80	90	Worst Problem

20. Where is your pain or problem now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face. Please place an X on the body form where the pain is worst now.

- | | | | | |
|---------------|-----------------|-----------------------|----------------|-----------------|
| Aching
△△△ | Numbness
=== | Pins & Needles
○○○ | Burning
□□□ | Stabbing
/// |
|---------------|-----------------|-----------------------|----------------|-----------------|



21. Please write in any other pertinent details about your problem: _____

22. Are there any other acute problems or crises in your life now?

- 1 No 2 Yes (explain) _____

X _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

X _____
DOCTOR'S INITIALS