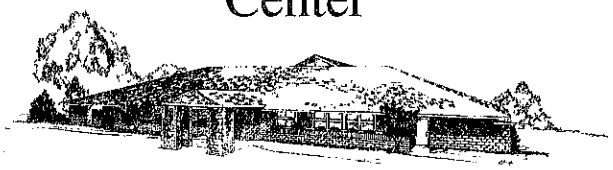
Virginia Orthopaedic Center



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New Patient / New Problem Questionnaire

NAME: _____ AGE: _____ DATE OF BIRTH: _____

E-MAIL ADDRESS: _____

1. What part of the body are you being seen for today? ___Shoulder ___Elbow ___Wrist ___Hand
   ___Hip ___Knee ___Ankle ___Foot
   ___Neck ___Back ___Other: _____
2. Is your problem the result of an injury? ___Yes ___No (if "No", then proceed with question #6)
3. What was the date of your injury? _____
4. How were you injured? ___Sports - please specify the sport: _____
   ___Car Accident ___Motorcycle Accident ___A fall
5. Where were you injured? ___Work ___School ___Home ___Other: _____
6. How long have you had this problem? (*Please specify a number*) ___Days ___Weeks ___Months ___Years
7. How would you describe the pain that you are experiencing? (Please check all which apply.)
   - Quality: ___Sharp ___Dull ___Throbbing
   - Severity: ___Mild ___Moderate ___Severe
   - Duration: ___Lasts for Minutes ___Lasts for hours ___Constant
   - Timing: ___Pain with exercise or activity ___Pain at rest ___Pain at nighttime
   - Context: ___Pain is getting worse ___Pain is staying the same ___Pain keeps recurring
   - Modifying factors: ___Better with rest ___Better with ice ___Better with limb elevation
   - Associated symptoms: ___Numbness ___Tingling ___Limb feels cold
8. What types of treatment have you had for this problem?
   ___Anti-inflammatory medications ___Surgery
   ___Cortisone injections ___No treatment
   ___Physical therapy ___Other: _____
9. How were you referred to us?
   ___Primary Care Physician ___High School
   ___Emergency Room ___Other: _____
10. Who is your Primary Care Physician: _____
11. Are you right or left handed? _____