New Problem Questionnaire

Please check a box as appropriate

Name:____ Age: _______Date:____________

1) Sex: ☐ Male or ☐ Female Height _______________ Weight ________________

2) Are you ☐ Right or ☐ Left Handed?

3) What brings you in today?____

____

____

4) What is your main problem?

☐ Pain ☐ Unstable or Dislocating Joint
☐ Numbness ☐ Swelling
☐ Weakness ☐ Stiffness
☐ Other (explain):____

5) How did your problem start? (give details as needed)

☐ Job Injury ☐ Sports Injury
☐ Motor Vehicle Accident ☐ Gradual or Slow Onset
☐ Other (explain):____

6) How long have you had this problem, approximately?________________________________

7) Is your pain: ☐ Aching ☐ Burning ☐ Dull ☐ Piercing ☐ Sharp ☐ Throbbing

8) Is your problem:

☐ Improving ☐ Worsening ☐ Staying the Same

9) Does your pain or problem awaken you from sleep? ☐ Yes ☐ No

10) Is your pain or problem intermittent? ☐ Yes ☐ No or Constant? ☐ Yes ☐ No

11) What worsens your problem? (give details as needed)

☐ Exercise ☐ Repetitive Motions ☐ Nothing
☐ Sitting ☐ Overhead Activities ☐ Rest
☐ Standing ☐ Going up and down stairs ☐ Walking
☐ Other (explain):____

12) What helps your problem? ☐ Brace ☐ Elevation ☐ Heat ☐ Ice ☐ Injection ☐ Massage ☐ Pain meds ☐ NSAIDs ☐ Physical therapy ☐ Rest ☐ Stretching ☐ Nothing Other (explain):_____________________

13) Are routine activities or walking limited because of your problem? ☐ Yes ☐ No

14) Do you use any assistive devices? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other:_____________

15) What tests have you had?

☐ X-rays ☐ Nerve Test (EMG or NCV)
☐ CT Scan or MRI ☐ Ultrasound ☐ Other:________________

17) What medicines are you taking for this problem?_____________________________________

18) Are you on or applying to any of the following programs because of your problem?

☐ Disability ☐ Worker's Compensation

19) What is your occupation?____

20) What is your present work status?

☐ Not Working Date last worked:__________________________

☐ Light Duty For how long?______________________________

☐ Regular Duty, no restrictions

21) If you are working, does your job require the following?

☐ Lifting How Many Pounds:_________ ☐ Extended Walking

☐ Frequent Bending & Lifting ☐ Continuous Standing

☐ Frequent Squatting or Kneeling ☐ Sitting

☐ Climbing ☐ Repetitive Motions

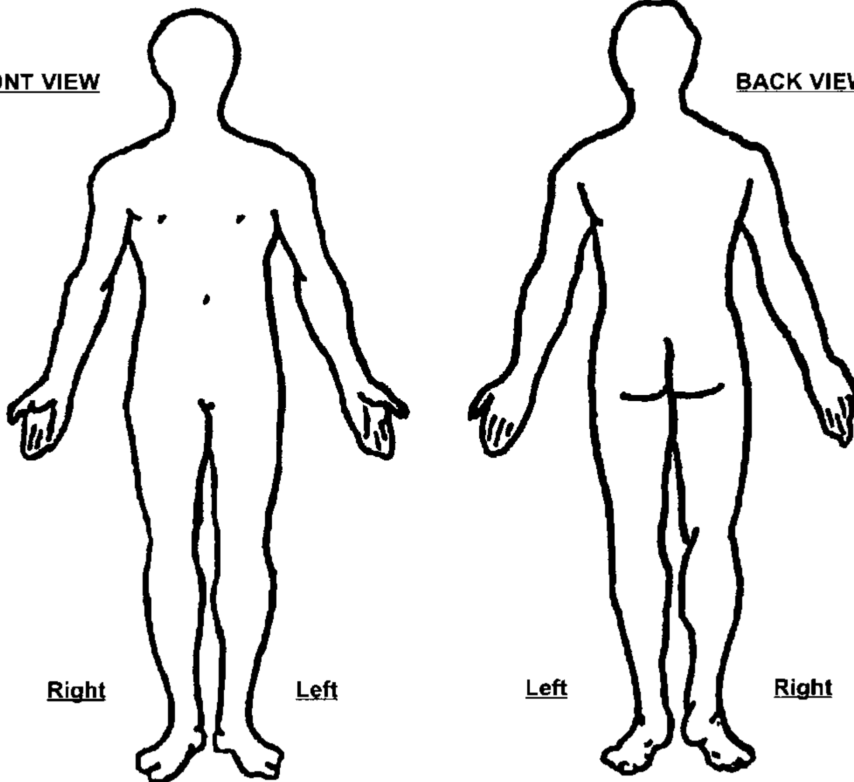
22) Any other acute problems in your life right now or anything else regarding your problem that you wish us to know?____

23) Please make a mark on the scale regarding the severity of your problem.

24) Mark the area(s) on your body where you feel the sensations described below, using the appropriate symbol. Include all pertinent areas and radiating pain.

○ ***Ache*** / ***Sharp Pain*** Δ ***Burning or Tingling*** # ***Numbness***

To complete the picture, draw in your face and place an "**X**" where the pain is worst now



X______________________________________ ____________ X_______________________

Signature of Patient, Parent, or Guardian Date Reviewed by MD

---SUPERFORM---

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

- ❑ Alcohol dependence ____/____/____
- ❑ Allergies ____/____/____
- ❑ Anemia ____/____/____
- ❑ Angina ____/____/____
- ❑ Anxiety ____/____/____
- ❑ Arthritis ____/____/____
- ❑ Asthma ____/____/____
- ❑ Blood clots ____/____/____
- ❑ Broken bones ____/____/____
- ❑ Cancer ____/____/____

Type: ___________________________________

- ❑ Chronic blood thinner use ____/____/____
- ❑ Chronic fatigue syndrome ____/____/____
- ❑ Chronic hepatitis ____/____/____
- ❑ Chronic kidney disease ____/____/____
- ❑ Chronic neck pain ____/____/____
- ❑ Chronic sinusitis ____/____/____
- ❑ Circulatory disease ____/____/____
- ❑ Colitis ____/____/____
- ❑ Congestive heart failure ____/____/____
- ❑ Chronic obstr pulm diseas ____/____/____
- ❑ Crohn's disease ____/____/____
- ❑ Depression ____/____/____
- ❑ Diabetes Type I ____/____/____
- ❑ Diabetes Type II ____/____/____
- ❑ Diarrhea ____/____/____
- ❑ Disc degeneration ____/____/____
- ❑ Duodenal ulcer ____/____/____
- ❑ Emphysema ____/____/____
- ❑ Esophageal reflux ____/____/____
- ❑ Gallbladder stones ____/____/____
- ❑ Goiter ____/____/____
- ❑ Gout ____/____/____
- ❑ Headache ____/____/____
- ❑ Heart attack ____/____/____
- ❑ Other heart disease ____/____/____

____

- ❑ Heart failure ____/____/____
- ❑ Hepatitis ____/____/____
- ❑ High blood pressure ____/____/____
- ❑ High cholesterol ____/____/____
- ❑ Irregular heart rhythm ____/____/____
- ❑ Hypertension ____/____/____
- ❑ Hyperthyroidism ____/____/____
- ❑ Insomnia ____/____/____
- ❑ Irritable bowel syndrome ____/____/____
- ❑ Hepatitis ____/____/____
- ❑ Kidney stones ____/____/____
- ❑ Other kidney disease ____/____/____

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- ❑ Liver disease ____/____/____
- ❑ Low blood pressure ____/____/____
- ❑ Migraines ____/____/____
- ❑ Mixed hyperlipidemia ____/____/____
- ❑ Obesity ____/____/____
- ❑ Osteoarthritis ____/____/____
- ❑ Osteoporosis ____/____/____
- ❑ Palpitations ____/____/____
- ❑ Rheumatoid Arthritis ____/____/____
- ❑ Sciatica ____/____/____
- ❑ Seizures/epilepsy ____/____/____
- ❑ Sleep apnea ____/____/____
- ❑ Stomach ulcer ____/____/____
- ❑ Stroke (CVA) ____/____/____
- ❑ Thyroid disease ____/____/____
- ❑ Tinnitus ____/____/____
- ❑ Tuberculosis ____/____/____
- ❑ Other: ____/____/____

____

Surgical History

Procedure	Date of surgery
______________________	______________
______________________	______________
______________________	______________
______________________	______________

Medications

List all medications you take, prescription and nonprescription, and their dosage:

❑ No medications

Medication	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Medication Allergies

__ No Known Drug Allergies

Medication	Reaction
______________________	______________________
______________________	______________________
______________________	______________________

Family History

Relation	Age	State of Health	Age of Death	Medical Problems or Cause of Death
Mother				
Father				
Sibling ☐Bro ☐Sis				
Sibling ☐Bro ☐Sis				
Sibling ☐Bro ☐Sis				
Grandfather (maternal)				
Grandmother (maternal)				
Grandfather (paternal)				
Grandmother (paternal)				

Social History

Do you use tobacco? ❑ Yes ❑ No ❑ Former Type of tobacco used? _______________/_________________
Packs per day? ____ Years smoked? ___________________ Year Quit? _______________
Other Tobacco units per day (cans, cigars, etc)? ____
Units per day? _______________________ Years used?_________________ Year Quit? _______________

Do you drink caffeine? ❑ Yes ❑ No Type? _____________________ Amount Daily? __________

Do you drink alcohol? ❑ Yes ❑ No ❑ Former Year Quit? ______________
Type? __________________________________ How much per week? ____
Amount? ________________________________ Last Drink? ____

Pediatric Social History:
School name: _______________________Grade in school: ______ Siblings: _______ Passive smoke exposure? Y / N

Review of Systems

Constitutional
❑ Chills
❑ Fever

HEENT
❑ Headache
❑ Nasal Congestion
❑ Vertigo/dizziness
❑ Vision loss

Respiratory
❑ Cough
❑ Shortness of breath (dyspnea)
❑ Recent infections
❑ Known TB exposure

Cardiovascular
❑ Chest pain (cardiac)
❑ Leg swelling
❑ Irregular heartbeat/palpitations

Gastrointestinal
❑ Abdominal pain
❑ Constipation
❑ Black tarry stools
❑ Diarrhea

Genitourinary
❑ Pain on urination
❑ Frequent urination
❑ Blood in urine

Metabolic/Endocrine
❑ Cold intolerance
❑ Hair loss
❑ Heat intolerance/hot flashes

Neurological
❑ Paresthesia/numbness
❑ Seizures

Psychiatric
❑ Anxiety
❑ Depression
❑ Insomnia

Integumentary
❑ Contact allergy
❑ Rash
❑ Skin infections

Hematologic
❑ Easy bleeding/ bruising
❑ History of blood clot

Immunologic
❑ Asthma
❑ Metal allergy/ environ.