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ORTHOPAEDIC INFORMATION QUESTIONNAIRE

Today's Date

To better know you and understand your orthopaedic health concerns, we ask your cooperation in answering the following questions completely and accurately. If you need help, please let us know.

NAME		DOMINANT HAND RIGHT ☐ LEFT ☐	
ADDRESS		AGE	BIRTHDATE
CITY		SEX MALE ☐ FEMALE ☐	
HOME PHONE	WORK PHONE	HEIGHT	WEIGHT
EMPLOYER		OCCUPATION	
IS THIS A WORKER'S COMPENSATION CASE? YES ☐ NO ☐		ARE LEGAL OR 3RD PARTY LIABILITY ACTIONS PENDING? YES ☐ NO ☐	

1. WHAT IS THE MAJOR BONE OR JOINT COMPLAINT THAT BRINGS YOU HERE TODAY?

2. DO YOU KNOW WHAT CAUSED THIS PROBLEM TO START? HOW DID THIS OCCUR?

3. WHEN DID THIS PROBLEM START?

DATE	ONSET...
	☐ UNNOTICED ☐ GRADUAL ☐ SUDDEN ☐ ACUTELY TRAUMATIC

4. HOW SEVERE IS YOUR PAIN INTENSITY?

- ☐ 10 EXCRUCIATING
- ☐ 9 HORRIBLE
- ☐ 8 VERY SEVERE
- ☐ 7 UNABLE TO FUNCTION
- ☐ 6 MAJOR PAIN
- ☐ 5 MODERATE PAIN
- ☐ 4 CONSTANT AWARENESS, BUT COPING
- ☐ 3 DISCOMFORTING
- ☐ 2 MILD, NOT BAD
- ☐ 1 NUISANCE
- ☐ 0 NONE

WHAT DOES IT FEEL LIKE?

- ☐ SHARP
- ☐ DULL ACHY PAIN
- ☐ NUMBNESS
- ☐ SWELLING
- ☐ REDNESS
- ☐ OTHER
- ☐ FEVER OR CHILLS
- ☐ GIVING WAY
- ☐ WEAKNESS
- ☐ FUNCTION LOSS

SPECIFY IF NEEDED

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6. IF YOU HAVE PAIN **WHERE** IS THE PAIN **CENTERED?**

DOES THE PAIN TRAVEL INTO OTHER PARTS OF THE BODY?

☐ SHOULDER ☐ LEGS ☐ BACK ☐ HAND ☐ FEET ☐ HEAD

☐ OTHER ____________

7. FREQUENCY OF YOUR PAIN IS:

☐ CONTINUOUS, EVERY DAY
☐ ONLY WITH ACTIVITY
☐ OFF & ON, BUT EVERY DAY
☐ PRESENT EVEN WHEN RESTING
☐ COMES AND GOES
☐ ONLY OCCASIONALLY

8. TIME OF DAY WHEN PAIN IS WORST?

☐ MORNING
☐ END OF DAY
☐ ALL DAY

DOES IT WAKE YOU UP OR PREVENT YOU FROM FALLING ASLEEP?

☐ YES ☐ NO

9. WHAT INCREASES THE PAIN?

☐ LYING DOWN
☐ SITTING
☐ GETTING UP TO WALK
☐ STANDING OR WALKING
☐ RUNNING OR EXERCISE
☐ PRESSURE ON THE AFFECTED AREA

10. PAIN IS RELIEVED BY?

☐ NOTHING
☐ RESTING OR LYING DOWN
☐ ACTIVITY
☐ MASSAGE OR HEAT
☐ SELF-DISTRACTING ACTIVITIES *EXAMPLE-TV OR READING*
☐ MEDICATION

11. WHAT MEDICATIONS ARE YOU NOW TAKING FOR THIS PROBLEM?

WE NEED TO KNOW THE **NAME** OF THE PILLS ____________

HAVE THESE PILLS RELIEVED THE PAIN? ☐ COMPLETELY ☐ PARTIALLY ☐ NOT AT ALL

12. WHAT DRUGS IF ANY GIVE YOU AN ALLERGIC REACTION?

1. ____________
2. ____________

13. WITH TIME HAS THE PROBLEM BEEN **IMPROVING** OR **WORSENING** IN SEVERITY?

14. HAVE YOU EVER HAD THIS TYPE OF PAIN BEFORE?

☐ YES ☐ NO

IF SO, WHEN?

15. WHAT OTHER DOCTORS, CHIROPRACTORS, OR THERAPISTS HAVE YOU SEEN FOR THIS ORTHOPAEDIC PROBLEM?

WHAT TREATMENTS HAVE BEEN TRIED SO FAR?

HAVE THEY HELPED?
☐ YES ☐ NO

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16. WHAT IS YOUR WALKING ENDURANCE?

☐ UNLIMITED ☐ 1 OR 2 MILES ☐ 2-3 BLOCKS ☐ HOUSEHOLD ONL

DO YOU USE ANY WALKING AIDE? ☐ NONE ☐ CANE ☐ WALKER ☐ CRUTCHES ☐ WHEELCHAIR ☐ BRACE OR SPECIAL SHOES

17. ACTIVITIES YOU ARE UNABLE TO DO BECAUSE OF YOUR ORTHOPAEDIC PROBLEM?

☐ NO LIMITS ☐ SHOPPING ☐ WORK AT MY JOB ☐ HOUSEWORK ☐ SPORTS

HOW LONG OFF WORK? ______

18. DOES THIS PROBLEM MAKE YOU FEEL...

☐ ANGRY? ☐ DEPRESSED? ☐ IRRITABLE?

HOW HAS THIS PROBLEM EFFECTED YOUR OVERALL QUALITY OF LIFE? ______

19. PLEASE RATE YOUR OVERALL PHYSICAL HEALTH *(CHECK ONE ONLY)*

☐ EXCELLENT ☐ VERY GOOD ☐ FAIR ☐ POOR

20. WHAT SURGERIES HAVE YOU HAD ON YOUR BONES OR JOINTS?

______

______

21. WHAT OTHER MAJOR SURGERY HAVE YOU HAD?

______

______

22. HAVE YOU HAD PROBLEMS WITH GENERAL OR SPINAL ANESTHESIA?

☐ YES ☐ NO

IF SO, WHAT WERE THEY? ______

23. DO YOU SMOKE?

☐ YES ☐ NO	PACK PER DAY?	# OF YEARS?

24. ALCOHOLIC BEVERAGES?

☐ NEVER ☐ SPECIAL OCCASIONS ONLY	#DRINKS ON WEEKEND	# DRINKS MID-WEEK

25. HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS IN THE PAST SIX MONTHS?

☐ CORTISONE (PILLS OR SHOTS) ☐ WATER PILLS ☐ HEART MEDICINE

☐ INSULIN ☐ HIGH BLOOD PRESSURE PILLS ______

26. WHAT OTHER PRESCRIPTION MEDICATIONS DO YOU TAKE? *(NAMES OF PILLS)*

1. ______
2. ______
3. ______
4. ______

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27. DO YOU HAVE ANY OTHER MEDICAL PROBLEMS AT THIS TIME?

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

28. DO YOU HAVE OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL DISEASES OR CONDITIONS?

- ☐ MEMORY LOSS
- ☐ SEIZURES
- ☐ LOSS OF CONSCIOUSNESS/BLACKOUTS
- ☐ STROKE OR HEAD INJURY
- ☐ PARKINSONISM

- ☐ MAJOR DEPRESSION
- ☐ THOUGHTS OF SUICIDE
- ☐ OVERWHELMING LIFE STRESS
- ☐ NERVOUS BREAKDOWN

- ☐ DIFFICULTY URINATING
- ☐ URINARY TRACT INFECTIONS
- ☐ KIDNEY STONES
- ☐ RENAL FAILURE

- ☐ RHEUMATOID ARTHRITIS
- ☐ GOUT
- ☐ BRITTLE OR WEAK BONES
- ☐ HISTORY OF BONE OR JOINT INFECTIONS
- ☐ BROKEN BONES OR JOINT INJURIES
- ☐ PERIPHERAL BLOOD VESSEL DISEASE
- ☐ VARICOSE VEINS
- ☐ BLOOD CLOTS IN YOUR LEG VEINS OR LUNGS
- ☐ PERIPHERAL NERVE INJURIES/DISEASE

- ☐ GENERALIZED WEAKNESS/LETHARGY
- ☐ STEADY WEIGHT LOSS
- ☐ CANCER: TYPE ____________________

- ☐ HEARING LOSS
- ☐ DIZZY OR SPINNING SENSATIONS
- ☐ LIGHTHEADEDNESS ON STANDING
- ☐ POOR EYESIGHT OR BLINDNESS
- ☐ CATARACTS OR GLAUCOMA

- ☐ THYROID DISEASE/GOITER
- ☐ DIABETES TYPE ____________________
- ☐ HARDENING OF THE ARTERIES
- ☐ HEART ATTACK
- ☐ IRREGULAR HEART RHYTHM
- ☐ HIGH BLOOD PRESSURE
- ☐ BLEEDING ABNORMALITIES

- ☐ DIFFICULTY BREATHING/ASTHMA
- ☐ BRONCHITIS OR EMPHYSEMA
- ☐ PNEUMONIA
- ☐ ULCERS OR GASTRITIS
- ☐ STONES IN GALLBLADDER
- ☐ JAUNDICE/HEPATITIS/LIVER DISEASE
- ☐ PANCREATITIS

- ☐ FREQUENT DIARRHEA OR CONSTIPATION
- ☐ DARK TARRY STOOLS

- ☐ SKIN DISEASE (PSORIASIS,LUPUS)
- ☐ SKIN ULCERS/SORES/OR RASH

Please review the questionnaire to make sure all questions are answered fully. We can help with clairification if necessary. THANK YOU. *Knowing you better will help us serve you better.*

THE INFORMATION I HAVE PROVIDED ON THIS QUESTIONNAIRE IS ACCURATE AND COMPLETE, TO THE BEST OF MY RECALL.

SIGNATURE____________________DATE ____________________