Pre-Exam Questionnaire - ORTHOPEDIC

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Have you ever had this pain or problem before?			Yes	No
1a) If yes, did you receive any treatments at that time?			Yes	No
1b) If yes, where?				
2. List the dates and results of any.	X-rays:			
	MRI's:			
3. Where is your pain or problem?	Neck	Lower back	Middle back	Other:
(check all that apply)	Elbow	Elbow	Shoulder/upper arm	
	Hip	Knee	Foot/ankle	
3a) Is it deep or on the surface?			Deep	On the surface
3b) Does it move or stay in one place?				
4. When did this problem first begin? _____/_____/20_____ (approximate date)				
5. How did it start?				
6. My pain/problem is slowly getting	worse	better	staying the same	
7. My pain bothers me	constantly	most of the time	only occasionally	once in awhile

8. On a scale from 1 to 10, what is the worst your pain has been in the past several days? _____/10

Mild discomfort *Moderate* *Unbearable, Severe*

1----------5----------10

9. Do you have any regular numbness or tingling?	Yes	No
10. What seems to make your pain worse?		
10a) When it does get worse, how long does it take before calming back down? _____		
11. What seems to make it feel better?		

_____ _____ ___/___/20___

Patient Name Signature Today's Date