Name:
DOB:
Chart:
Age:
Date:

THE ORTHOPAEDIC GROUP P.C.
Experience. Excellence. Trust.

NEW COMPLAINT QUESTIONNAIRE

Name: _____ Age:_____ Date:_____

1. Where is your problem?

☐ Shoulder	☐ Hip	☐ Neck
☐ Arm	☐ Thigh	☐ Back
☐ Elbow	☐ Knee	
☐ Forearm	☐ Leg	
☐ Wrist	☐ Ankle	
☐ Hand	☐ Foot	

2. Which side is bothering you?

☐ Right ☐ Left ☐ Both sides

3. When did it start? ____/ ____/ _____

4. Did the problem start: ☐ Suddenly ☐ Gradually

5. Is your problem getting: ☐ Worse ☐ Better ☐ Staying the same

6. Was this a result of an injury? ☐ Yes ☐ No

If yes, please describe below how it happened:

_____

_____

_____

7. How bad is your pain?

(No pain) 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

8. How would you describe your pain (check only one)?

☐ Constant ☐ Comes and goes

9 . How would you describe your pain (check all that apply)?

☐ Dull ☐ Sharp ☐ Burning
☐ Throbbing ☐ Aching
☐ Other (explain) - _____

10 . What makes your problem better?

_____

11 . What makes your problem worse?

_____

12 . Which of the following treatments have you had for your problem?

			Did you get relief?		
	Yes	No	Yes	No	
Medication	☐	☐	☐	☐	Type: _____
Physical Therapy	☐	☐	☐	☐	How long did you attend? _____
Injections	☐	☐	☐	☐	Describe: _____
Surgery	☐	☐	☐	☐	Describe: _____
Other	☐	☐	☐	☐	Describe: _____

13 . Is there a legal case involved with this injury? ☐ Yes ☐ No

14 . Please list below any changes in your medical history since your last visit (new medical problem, surgery, medicines, allergies, etc.). ☐ **No change in medical history**

_____

_____

_____