Name:
DOB:
Chart:
Age:
Date:

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

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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**

____

____

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