



PORTNER
ORTHOPEDIC
REHABILITATION
INCORPORATED

General Patient Questionnaire

Name: _____ Date: _____ Occupation: _____

1. Which hand do you write with?

- Right Left Ambidextrous (both)

2. What is your Current work status?

- Regular Off Part Time/Regular Duty Part Time/Light Duty
 Full Time/Light Duty Retired Unemployed

3. How were you referred?

- Friend/Family Television Yellow Pages Emergency Room
 Website Website Radio Self Referred
 Newspaper Other: _____ Referred by Dr. _____

4. What is your Main Complaint? (Choose one)

- Pain Numbness or Tingling Weakness Other: _____

Where on your body is this felt? _____

5. Do you have any other complaints?

- No
 Yes- (Please Explain): _____

6. What is your pain level (how sever is your pain)? ("10" = TERRIBLE)

When it is at its **WORST**: 1 2 3 4 5 6 7 8 9 10

When it is at its **LEAST**: 1 2 3 4 5 6 7 8 9 10

7. How quickly did your symptoms begin?

- Suddenly Gradually Suddenly, then gradually worsened Don't remember
 Other: _____

8. Since your symptoms have started, has your condition

- Improved Worsened Stayed the same Hard to Say

9. Have you had any similar problem in the past?

- No Yes (if YES please complete the previous episode questionnaire) *

10. Have you previously had treatments for this Problem?

- No Yes (If Yes refer to Question 11)

11. If Yes Please indicate If the treatment has helped:

- | | | | |
|--|---------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Medication: | <input type="checkbox"/> Helped | <input type="checkbox"/> Did Not Help | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Physical Therapy: | <input type="checkbox"/> Helped | <input type="checkbox"/> Did Not Help | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Massage: | <input type="checkbox"/> Helped | <input type="checkbox"/> Did Not Help | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Chiropractor: | <input type="checkbox"/> Helped | <input type="checkbox"/> Did Not Help | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Traction: | <input type="checkbox"/> Helped | <input type="checkbox"/> Did Not Help | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Acupuncture: | <input type="checkbox"/> Helped | <input type="checkbox"/> Did Not Help | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Injections: | <input type="checkbox"/> Helped | <input type="checkbox"/> Did Not Help | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Surgery: | <input type="checkbox"/> Helped | <input type="checkbox"/> Did Not Help | <input type="checkbox"/> Worsened |

12. Have you had any tests performed for THIS EPISODE?

- No Yes (If Yes see below)

Test Performed	Body area:	When?
X-ray		
EMG		
MRI		
CAT Scan		
Bone Scan		
Other (Give Details)		

13. Have you seen other Doctors for THIS EPISODE?

- No Yes - Doctor(s): _____

14. Work History since THIS EPISODE began?

- Never off work Off since onset Was off now regular Was off, now light duty
 Other: _____

15. In your every day routine, are you still able to continue all your usual activities??

- Yes- I can do everything No - I have difficulties with certain activities:

Activity	No Difficulty	Difficulty
Putting on shoes, sox	<input type="checkbox"/>	<input type="checkbox"/>
Dressing upper body	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>
Grooming hair	<input type="checkbox"/>	<input type="checkbox"/>
Brushing teeth	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Washing Dishes	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>
Vacuuming	<input type="checkbox"/>	<input type="checkbox"/>
Taking out the rubbish	<input type="checkbox"/>	<input type="checkbox"/>
Gardening/Yard work	<input type="checkbox"/>	<input type="checkbox"/>

16. *WOMEN ONLY*- Are you pregnant?

- Definitely Not Not Sure Last Menstrual Period: ___/___/___
 Yes- Due Date ___/___/___

17. Do you have a history of cancer?

- No Yes Type: _____ Year Diagnosed: _____

18. Are you currently taking any medications?

None Yes, please list: _____

19. Are you taking Vitamins or supplements?

None Glucosamine Multi-Vitamins
 Other: _____

20. Do you have any allergies?

None Yes, please list: _____

21. Do you drink Alcohol?

No Yes- (See below)

i. If yes, how much?

Socially (rare) 1-2x/week 3-5x/week Daily

22. Do you smoke?

No Yes (See below)

i. If yes, how much?

Few a day Half a pack a day 1 pack a day 2 packs a day

If Quit, when? _____ Years ago

For how many years have you smoked? _____ Years

Other: _____

23. What is your living situation?

Live alone Live with roommates Live with spouse/partner
 # of kids _____

24. Does your family have a history of Arthritis, Bone, Nerve, or Muscle problems?

No Not Sure Yes, Give Details: _____

25. Do you have any of the following conditions?

Allergies: No Yes
Angina: No Yes
Asthma: No Yes
Heart Disease: No Yes
Stroke: No Yes
Blood Pressure: No Yes
Diabetes: No Yes
Kidney Disease: No Yes
Other: _____

Gout: No Yes
Thyroid: No Yes
Lung Cancer: No Yes
Epilepsy: No Yes
Osteoporosis: No Yes
Arthritis: No Yes
Gastritis/ Ulcer: No Yes
Bowel Disease: No Yes

26. Do you have any of the following symptoms?

Fever: No Yes
Chills: No Yes
Weight Loss: No Yes
Dizziness: No Yes
Headache: No Yes
Eye Problems: No Yes
Ringing in the ears: No Yes
Chronic Diarrhea: No Yes
Difficulty swallowing: No Yes
Heartburn/ Acid: No Yes
Constipation: No Yes
Abdominal Pain: No Yes

Chronic fatigue: No Yes
Chronic Cough: No Yes
Chest Pain: No Yes
Palpitations: No Yes
Night Sweats: No Yes
Depression: No Yes
Anxiety: No Yes
Irritability: No Yes
Urine Incontinence: No Yes
Genitals Numbness: No Yes
Legs/Hands Swelling: No Yes
Rash: No Yes