

Dictated: Yes/ No

Date Dictated \_\_\_\_\_

# SCOS

South County Orthopedic Specialists

MR#

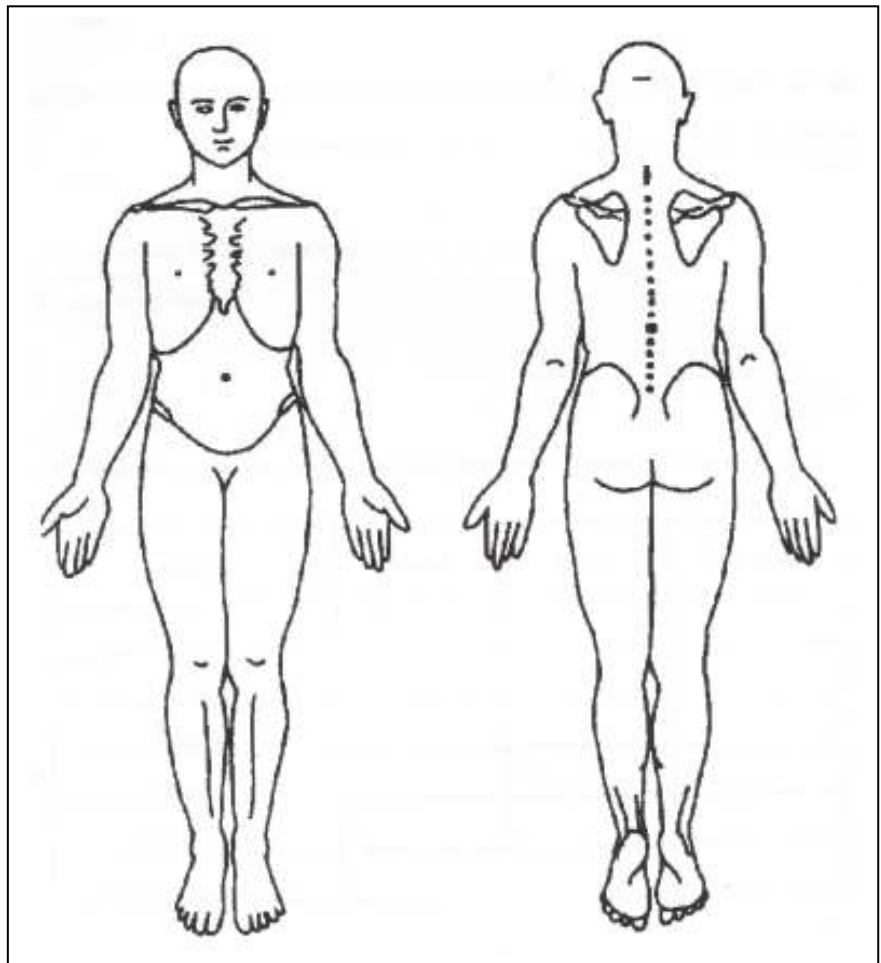
## New Patient Questionnaire

Please complete this form as thoroughly as possible to help Dr. Johnson with your evaluation and treatment plan.

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First M.I.  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_ ft \_\_\_\_ in Weight: \_\_\_\_ lbs  
 Referring M.D. \_\_\_\_\_  
 Primary M.D.(if different) \_\_\_\_\_

1. What is the main reason for today's visit?
2. Please diagram the **location and type of pain/symptoms** you are having. (use symbols)

Symbol	Sensation
OOO OOO	Pins and Needles
//// ////	Stabbing Sharp
XXX XXX	Burning
=== ===	Numbness
AAA AAA	Aching/ cramping
+++ +++	Others



3. When did you first start having this problem? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Are your symptoms related to an injury?

NO (go to next question)

YES, answer the following:

a. Date of injury \_\_\_\_\_ (month, day, year)

b. Injury type

c. The injury was (choose one)

Work related

Not work related

d. Please describe your injury in as much detail as possible:

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5. Have you seen another physician for this problem? If so, please list doctor(s).

6. Which of the following therapies have you tried for this problem? (check all that apply)

Pain pills (e.g. Tylenol w/ Codeine, Darvocet, etc)

Muscle Relaxants (e.g. Flexeril, Baclofen etc.)

Anti-inflammatories (e.g. Motrin, Advil, Vioxx, Celebrex etc. )

Chiropractic manipulations

Acupuncture

Physical Therapy (when?, and did it help?)

7. Have you had any spine injections (epidurals)?

8. Have you had **surgery for your neck or back?**

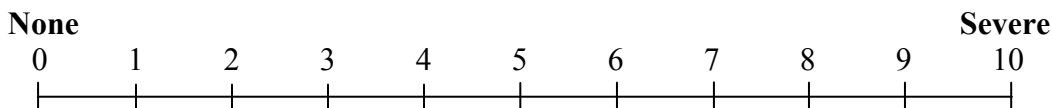
NO

YES, I have had \_\_\_\_\_ # of surgeries on my neck/back.

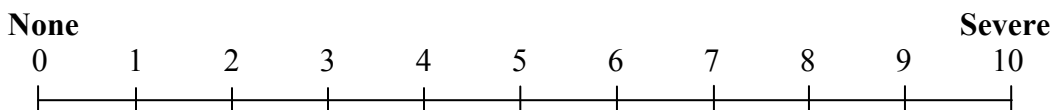
(please complete the table below)

Surgery date	Type of Surgery

9. What is your pain level **today**? (mark pain level with an "X")



10. What is your **average** pain level?



11. How would you describe your symptoms?

- a. Always there
- b. Comes and goes
- c. Activity related
- d. Worse at night

12. Have your symptoms been:

- a. Improving
- b. Unchanging
- c. Worsening

13. What percentage of your pain is leg/arm compared to back/neck? (for example 50% leg: 50% back if they hurt the same)

\_\_\_\_\_ % Leg Pain/Arm Pain vs. \_\_\_\_\_ % Back Pain/Neck Pain (**total adds to 100%**)

14. Have you experienced any loss of control of your bowel or bladder?

- a. Yes
- b. No

15. Have you experienced any fevers, chills, or night sweats?

- a. Yes
- b. No

16. Have you experienced any numbness or weakness in your arms or legs?

- a. Yes
- b. No

17. Please answer the follow about your **living and social situation**.

Currently Employed?  YES  NO

Occupation: \_\_\_\_\_

18. Have you hired a lawyer for this injury?  YES  NO

**End of questionnaire. Thank you very much for your time in completing this form.**

Reviewed by \_\_\_\_\_

Date \_\_\_\_\_