Name:______________________DOB:_______________Date of Appt:_________________

Initial Visit & New Problem Questionnaire

Have you had any x-rays, CT/MRI of the affected body part? When/Where?_________________________________

What is the main problem/complaint today?____ RT LT Both

Were you referred to KPO? Yes No If so, by whom?_____________________________________

Who is your primary care provider?____

Is this visit related to a Workman's Compensation Claim?______________________________ Injury date_____

Review of Systems: Answer/circle all that apply.

Have you had any unexplained fever, chills, sweats, or weight change?
Eyes: Any vision changes or problems?
Ears/Nose/Throat: Any abnormalities?
Cardiovascular: Chest pain, palpitations, rapid/slow heartbeat, leg swelling, blood clots?
Respiratory: cough, shortness of breath, breathing problems?
Gastrointestinal: Stomach, liver, or digestive problems?
Kidney: Kidney disorder, incontinence, kidney stone?
Skin: rash, jaundice, or other skin disorder?
Neurological: Dizziness, fainting, headache, seizure, weakness, tremor, numbness, tingling?
Hematologic/blood: bleeding disorder, excessive bleeding, blood clot, clotting disorder?
Psychiatric: Anxiety, depression, excessive stress?
Anesthesia: Any problems or complications associated with anesthesia?
Infection: surgical infection, MRSA, abscess, cellulitis?

Please list all current medical conditions (e.g. diabetes, high blood pressure, thyroid disorders, *etc*.)

1.______________________________________5.____

2.______________________________________6.____

3.______________________________________7.____

4.______________________________________8.____

Name:______________________DOB:_______________Date of Appt:_________________

Please list any past surgeries and the approximate date:

1._____________________________________ 5._____________________________________

2._____________________________________ 6._____________________________________

3._____________________________________ 7._____________________________________

Are there any diseases that run in your family? Please list:____

What is your occupation? _____________________________Are you married or single?_________________
Do you smoke? Yes No If yes, how often? _____________________________________
Do you drink alcohol? Yes No If yes, how often? ______________________________

Please list any medications you are allergic to, and your allergy:______________________________________

Please list all current medications and the dosage:

1._____________________________________ 5._____________________________________

2._____________________________________ 6._____________________________________

3._____________________________________ 7._____________________________________

4._____________________________________ 8._____________________________________

Are you on a Pain Medication Contract? Yes NO Who is the managing physician?_____________________

Which Pharmacy do you prefer?____

Vitals:

Height___________ Weight___________ BP______________ HR__________ Resp____________

Name:______________________DOB:_______________Date of Appt:_________________

Detailed Extremity Questionnaire

What body part are you here for evaluation?______________________________ Right Left Both

What is the primary reason for visit/complaint?____

When did this problem begin?_______________________ Injury? Yes No Date of injury________

What do you think the symptoms are due to (injury, or other)?_____________________________

Where are your symptoms located? (front, back, side, deep, etc)______________________________

What is the character of your symptoms? (constant, intermittent, sharp, dull, etc)__________________

Radiation—does the pain or symptom travel anywhere?

What makes symptoms worse?____

What makes symptoms better?____

Do you have any other symptoms?____

Any previous similar symptoms in the past?____

Any prior other problems/injury/surgery with this body part?_________________________________

Have you had prior evaluation of this problem?____

Have you had any prior treatment of this problem?____

Do you have specific limitations related to this problem?____________________________________

For arm/shoulder problems, are you right or left handed? Right Left Both

What are you seeking today? Discuss options conservative treatment consider surgery 2nd opinion