

Ventura Orthopedics

Current Problem Questionnaire

Instructions: This is a scanned document, Please fill in the circle Do not use an X, check mark, or line

Patient Name:		Date:
DOB:	Height:	Weight:
Referring Physician:		

- I. Which side is affected? Right Left Bilateral
- Problem involves the: Shoulder Elbow Forearm Wrist Hand
- Finger Neck Hip Thigh Knee
- Leg Ankle Foot Toe Back
- II. Was there an injury which you believe directly resulted in your symptoms? Yes No (If no, skip to IV.)
- If so, what is the date of injury: _____
- Is the injury work related? Yes No
- Is this the result of a motor vehicle accident? Yes No
- III. Please give an approximate time (date, month, or year) when the symptoms began: _____
- IV. Describe the injury and/or development of your problem: _____
- V. Have you sought medical treatment for this problem prior to this visit? Yes No
- If so, where: Emergency Room Urgent Care Physician's Office Other
- Name of care provider and/or facility who treated you: _____
- What kind of treatment was given? Brace/Splint Crutches Cast Therapy Chiropractic
- What medication was given? Narcotic (Vicodin, Codeine, etc) Anti-inflammatory (Advil, Motrin, etc)
- Muscle Relaxer (Flexeril, Soma, etc) Corticosteroid (Medrol Dosepak) Injection
- Other: _____
- VI. Have you had any studies of the involved area within the past year? X-Rays MRI
- CT/CAT Scan Nerve Test Arthrogram Myelogram Discogram
- Have you had surgery on this body part? Yes No
- Have you had symptoms or an injury to this area before? Yes No
- If so, please describe: _____
- VII. Are you getting: Better Worse No Change
- Quality of your pain: None Mild Moderate Severe
- Type of pain: Sharp Dull Burning Aching Other: _____
- Constant Present only at times or with certain activities
- Does the pain radiate: Yes No If yes, where on your body: _____
- Is there: Swelling Numbness/Tingling Weakness A Mass Deformity

