OPAORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

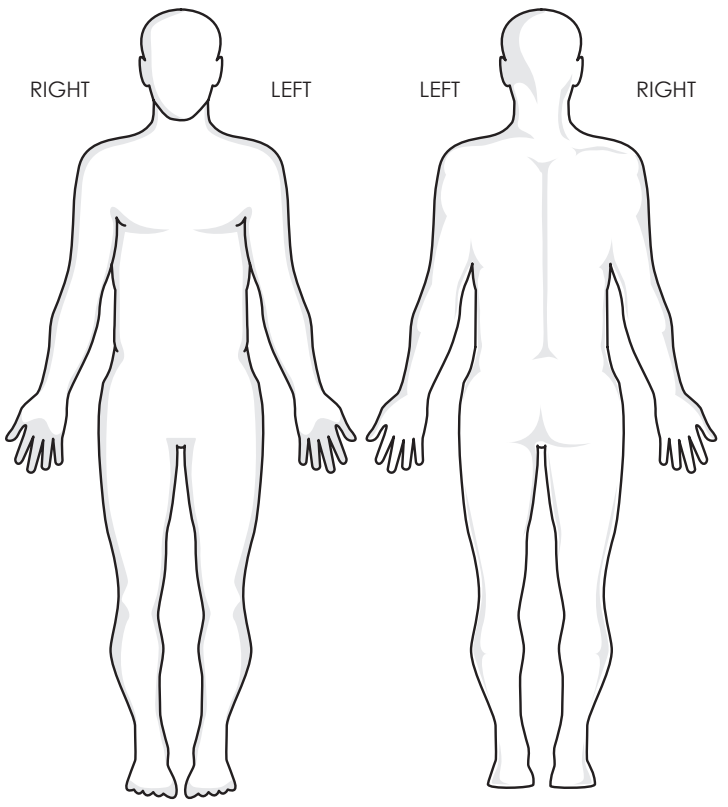
PATIENT INTAKE QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____ AGE: _____
LAST FIRST MIDDLE INITIAL MM/DD/YYYY

PAIN DRAWING

Mark these drawings using the symbols below that best describes your pain.

Pain **X** Numbness **O** Weakness **=** Ache **◊** Stabbing ****



DATE OF ONSET/INJURY _____

DURATION OF PAIN _____

LOCATION OF PAIN
(Indicate body part where pain is present and then total pain to 100%)

BACK	_____ %	BUTTOCK	_____ %
LEFT LEG	_____ %	RIGHT LEG	_____ %
NECK	_____ %	SHOULDER	_____ %
LEFT ARM	_____ %	RIGHT ARM	_____ %

PAIN AGGRAVATED BY:

☐ STANDING ☐ SITTING ☐ WALKING
☐ SLEEPING ☐ DRIVING ☐ STAIRS
☐ BENDING FORWARD ☐ BENDING BACKWARD ☐ OTHER _____

PAIN RELIEVED BY:

☐ STANDING ☐ SITTING ☐ WALKING
☐ SLEEPING ☐ DRIVING ☐ STAIRS
☐ BENDING FORWARD ☐ BENDING BACKWARD ☐ OTHER _____

TREATMENT ATTEMPTED:

☐ NARCOTICS ☐ ACUPUNCTURE ☐ INJECTIONS
☐ CHIROPRACTIC ☐ MASSAGE ☐ SURGERY
☐ PHYSICAL THERAPY ☐ ANTI INFLAMMATORIES ☐ OTHER _____

Do you have numbness/weakness in your arms/legs?
☐ YES ☐ NO

Do you have any difficulties with bowel or bladder function?
☐ YES ☐ NO

How far can you walk before having to stop and rest?
_____

Do you use a cane or walker?
☐ YES ☐ NO

SEVERITY OF PAIN: (AT REST)

(NONE) 0 1 2 3 4 5 6 7 8 9 10 (INTOLERABLE)

SEVERITY OF PAIN: (WITH ACTIVITY)

(NONE) 0 1 2 3 4 5 6 7 8 9 10 (INTOLERABLE)

The above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE _____ DATE _____

M.D. REVIEW _____ DATE _____