Medical Evaluation Questionnaire

1. What is your full name?_____
2. What is your date of birth?_____
3. Are you? ❑ Right handed ❑ Left handed ❑ Either
4. What is the date of your injury? _____
5. Have you ever had any previous problems or injuries, including any other work, recreational, or motor vehicle injuries?

   ❑ Yes ❑ No ❑ Not sure

   If yes, please describe:_____
   _____
   _____

6. Have you ever had any difficulties prior to the date of your injury which were similar to those you are now experiencing?

   ❑ Yes ❑ No ❑ Not sure

   If yes, please describe:_____
   _____
   _____

7. Please describe how your injury occurred:_____
   _____
   _____

8. What problems did you have at that time?_____
   _____
   _____

9. What did you do following the injury?_____
   _____

10. Have you had any additional injuries since the date of injury in question #4?_____
    _____

11. What is your greatest concern at this time?_____
    _____

If you are not having difficulty with pain, proceed to question 18.

12. Where is your pain located?_____

_____

13. How would you describe your pain (ache, burn, sharp, etc,)?_____

14. What makes your pain worse?_____

_____

15. What makes your pain better?_____

_____

16. How frequent is your pain?

- ❑ Constant (present ¾ to all of the time)
- ❑ Frequent (present ½ to ¾ of the time)
- ❑ Occasional (present ¼ to ½ of the time)
- ❑ Intermittent (present less than ¼ of the time)

17. On a scale from 0 (no pain) to 10 (excruciating pain),

	No pain ⟷ Excruciating									
a. What number would you put on your pain at this time?	1	2	3	4	5	6	7	8	9	10
b. During the past month, what has it averaged?	1	2	3	4	5	6	7	8	9	10
c. During the past month, what is the highest it has been?	1	2	3	4	5	6	7	8	9	10
d. During the past month, what it the lowest it has been?	1	2	3	4	5	6	7	8	9	10

18. Are you having any other difficulties (numbness, weakness, etc.)? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe the difficulties in detail._____

_____

_____

19. Are there any tasks difficult for you to perform? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe the tasks which are most difficult for you:_____

_____

_____

a. How much can you lift occasionally? _____lbs.

b. Can you lift a gallon of milk? ❑ Yes ❑ No ❑ Not sure

c. Can you lift a heavy bag of groceries? ❑ Yes ❑ No ❑ Not sure

d. Can you lift a pail of water? ❑ Yes ❑ No ❑ Not sure

e. How long can you sit at one time? _____ Stand?_____ Walk?_____

20. Who were you employed by when you were injured?_____

21. How long had you been working there?_____

22. What was your job title?_____

23. What did this job involve?_____

_____

_____

24. What type of work have you performed previously?_____

25. Have you held any other jobs since your injury? ❑ Yes ❑ No

If yes, please describe:_____

26. What is your level of education?_____

27. Are you working now? ❑ Yes ❑ No

If yes, please describe your present job:_____

If no, when did you last work?_____

28. Has your doctor, or anyone, prescribed any work restrictions? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe these restrictions:_____

_____

_____

28. Where do you live?_____

29. Who lives with you?_____

30. Please describe your typical day:_____

31. Are you involved in any significant activities or recreational pursuits? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

In the past? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

32. Do you smoke? ❑ No ❑ Yes, in the past but I quit ❑ Yes, _____packs per day

32. How many alcoholic beverages do you have per week?_____

33. Have you had any medical (non-surgical) hospitalizations? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

_____

_____

34. Have you had any operations? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

_____

_____

35. Are you taking any prescribed medications? ❑ Yes ❑ No ❑ Not Sure

If yes, please list:_____

_____

_____

36. Are you allergic to any medication? ❑ Yes ❑ No ❑ Not Sure

If yes, please list:_____

_____

_____

37. Have you had any other medical problems? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

_____

_____

38. Do any diseases run in your family? ❑ Yes ❑ No ❑ Not Sure

If yes, please describe:_____

_____

_____

39. Please provide any other comments which may assist us in understanding your situation:_____

_____

_____

_____

_____

_____

_____

Thank you for your assistance. At the time of the visit we will review this information in further detail.

Pain Drawing

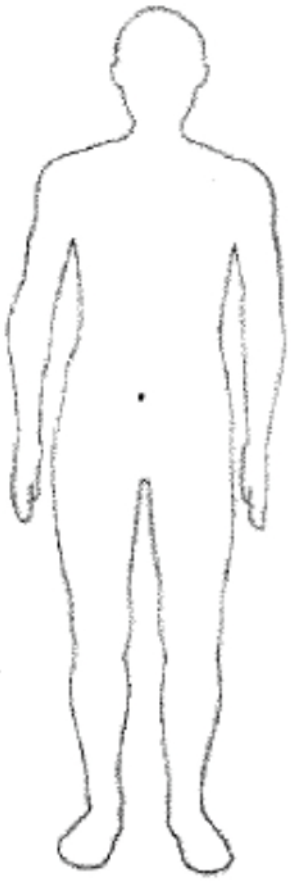
Name _____ **Date** _____

WHERE IS YOUR PAIN NOW?

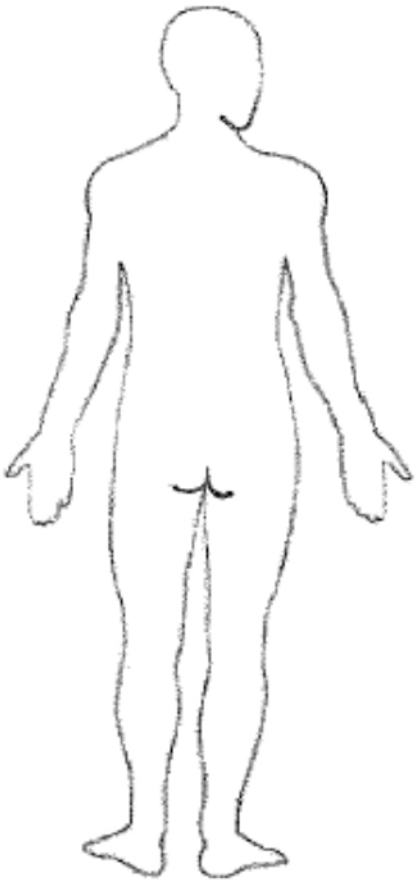
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

SYMBOLS					
Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
▲▲▲	= = =	ooo	X X X	/ / /	•••

FRONT VIEW



BACK VIEW



Pain Disability Questionnaire

Name _____ **Date** _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally — *Unable to work at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — *Need help with all my personal care*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
   Travel anywhere I like — *Only travel to see doctors*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
   No problems — *Cannot sit /stand at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems — *Cannot do at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — *Cannot do at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
   No problems — *Cannot walk/run at all*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
   No decline — *Lost all income*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
   No medication needed — *On pain medication throughout the day*
   0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors — *See doctors weekly*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problem — *Never see them*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
    No interference — *Total interference*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    Never need help — *Need help all the time*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression/tension — *Severe depression / tension*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
    No problems — *Severe problems*
    0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

*Quick*DASH

Please complete this is you are having problems with your arms.

Name _____ **Date** _____

Instructions: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer every question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.	*No Difficulty*	*Mild Difficulty*	*Moderate Difficulty*	*Severe Difficulty*	*Unable*
1. Open a tight or new jar.	*1*	*2*	*3*	*4*	*5*
2. Do heavy household chores (e.g., wash walls, floors).	*1*	*2*	*3*	*4*	*5*
3. Carry a shopping bag or briefcase.	*1*	*2*	*3*	*4*	*5*
4. Wash your back.	*1*	*2*	*3*	*4*	*5*
5. Use a knife to cut food.	*1*	*2*	*3*	*4*	*5*
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	*1*	*2*	*3*	*4*	*5*

	Not at All	*Slightly*	*Moderately*	*Quite A Bit*	*Extremely*
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	*1*	*2*	*3*	*4*	*5*

	Not Limited At all	*Slightly Limited*	*Moderately Limited*	*Very Limited*	*Unable*
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	*1*	*2*	*3*	*4*	*5*

Please rate the severity of the following symptoms in the last week.	*None*	*Mild*	*Moderate*	*Severe*	*Extreme*
9. Arm, shoulder or hand pain.	*1*	*2*	*3*	*4*	*5*
10. Tingling (pins and needles) in your arm, shoulder or hand.	*1*	*2*	*3*	*4*	*5*

	No Difficulty	*Mild Difficulty*	*Moderate Difficulty*	*Severe Difficulty*	*So Much Difficulty That I Can't Sleep*
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	*1*	*2*	*3*	*4*	*5*

AAOS Lower Limb Outcome Scale

Please complete this is you are having problems with your legs.

Name _____ **Date** _____

Instructions: These questions ask your views about your lower limb (leg).

	Not at All	*Mildly*	*Moderately*	*Very*	*Extremely*		
1. During the past week, how stiff was your lower limb?	*1*	*2*	*3*	*4*	*5*		
2. During the past week, how swollen was your lower limb?	*1*	*2*	*3*	*4*	*5*		
	Not Painful	*Mildly Painful*	*Moderately Painful*	*Very Painful*	*Extremely Painful*	*Could not do because of pain*	*Could not do because of Other*
3. Walking on flat surfaces?	*1*	*2*	*3*	*4*	*5*	*6*	*7*
4. Going up or down stairs?	*1*	*2*	*3*	*4*	*5*	*6*	*7*
5. Lying in bed at night?	*1*	*2*	*3*	*4*	*5*	*6*	*7*
	Did not need support	*Mostly walked without support*	*Mostly used 1cane / crutch*	*Mostly used 2 canes / crutches*	*Used a wheelchair*	*Mostly used other supports / someone*	*Unable to get around*
6. Which statements best describes your ability to get around most of the time during the **past week**?	*1*	*2*	*3*	*4*	*5*	*6*	*7*
	Not at All	*Mildly*	*Moderately*	*Very*	*Extremely*	*Cannot do it at all*	
7. How difficult was it for you to put on or take off socks/stockings during the **past week**?	*1*	*2*	*3*	*4*	*5*	*6*	

Please complete the following after your visit with the physician and provide this to the physician or the physician's staff prior to your departure.

Satisfaction Survey

Our goal is to provide the highest quality services. We welcome your feedback about today's visit. Please provide this to a member of our staff prior to your departure. Thank you.

	Agree	Disagree
1. I was treated with dignity and respect by the staff	❑	❑
2. The physician appeared thoughtful and thorough	❑	❑
3. I did NOT sustain any new or further difficulties during the exam.	❑	❑
4. Overall, I was pleased with the quality of today's visit.	❑	❑

Comments:

Name:_____ Date:_____