**FREDERICKSBURG ORTHOPAEDIC ASSOCIATES**
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ORTHOPAEDICS
JOINT • SPINE • SPORTS • HAND • TRAUMA

# Reason for Visit Questionnaire

AP# ___________________ Today's Date: __________________

Patient's Full Name: ______________________________________Age: _________ Date of Birth:_________________

Occupation: ___________________________ Primary Care Physician:_______________________________________

Were you referred to our practice? [ ] NO [ ] YES If yes, referring physician/facility:____________________________

Date of Injury OR Onset of Complaint: __________________________________________________________________

What is your chief complaint? (the reason you made your appointment) Please indicate right and left as appropriate.

___________________________________________________________________________________________________

Describe how you were injured, or if there was no injury briefly describe the onset of your complaint.

___________________________________________________________________________________________________

Is your chief complaint related to an auto accident? [ ] NO [ ] YES

Is this a work related injury? [ ] NO [ ] YES If yes, list worker's comp. insurance company:________________________

Are you currently working? [ ] NO [ ] YES

What physician or medical facility, if any, has treated you for the above medical condition? Please include dates of treatment:

_______________________________________________________________________________________________________

Have you had any previous testing? [ ] NONE [ ] X-Ray [ ] MRI [ ] CT scan [ ] Nerve Study [ ] Other: _____________

What treatment(s)/medication(s) have you tried? _________________________________________________________

___________________________________________________________________________________________________

Are you using any assistive devices? [ ] NONE [ ] Cane [ ] Crutches [ ] Walker [ ] Sling [ ] Brace [ ] Splint [ ] Other_____

What would you rate your pain level? (Please Circle) No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

What makes your pain worse? ______________________________________________________________________

Is pain better when leaning forward? [ ] NO [ ] YES

What makes your pain better? ______________________________________________________________________

Do you have night pain? [ ] NO [ ] YES If yes, does pain interfere with sleep? [ ] NO [ ] YES

**How would you describe your pain?** [ ] constant [ ] intermittent [ ] dull [ ] sharp [ ] stabbing [ ] aching

[ ] cramping [ ] burning [ ] night pain [ ] tingling [ ] shooting [ ] Other: _____________________________________

**Have you had any of the following?** [ ] limping [ ] swelling [ ] stiffness [ ] radiating pain [ ] catching [ ] locking

[ ] grinding [ ] numbness [ ] instability [ ] weakness [ ] giving out [ ] warmth [ ] decreased range of motion

[ ] painful range of motion