

**Bone & Joint Center, P.C./ACES**

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Chicago IL, 60641

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**PATIENT INFORMATION QUESTIONNAIRE**

Name: \_\_\_\_\_

First

Middle

Last

Address: \_\_\_\_\_

Street address

City

State

Zip code

Height: \_\_\_\_feet \_\_\_\_inches      Weight: \_\_\_\_Lbs.      Age: \_\_\_\_

Please check one: I am  right-handed or I am  left-handed

What kind of work do you do? (Please check one)

- Construction    Desk job    Driver    Teacher    Executive/Professional
- Factory    Homemaker    Retired    Sales    Student    Other \_\_\_\_\_

If you are **not** working now, **when** did you last work? \_\_\_\_/\_\_\_\_/\_\_\_\_

Does/did it require lifting?  Yes  No

How often?    Rarely       Frequently       Constantly

How much?    10 Lbs. or less       10-50 Lbs.       50-100 Lbs.       More than 100 Lbs.

As part of your work, do you commonly? (Please check all those that apply)

- Squat    Push    Pull    Lift overhead    Climb ladders/stairs    Reach    Bend    Stoop

Is this a Workman’s Compensation case?  Yes  No

Company name: \_\_\_\_\_ Tel: (    ) \_\_\_\_\_

Company address: \_\_\_\_\_

Street

City

State

Zip code

Is this a legal or third person liability case?  Yes  No

Lawyer’s name: \_\_\_\_\_ Tel: (    ) \_\_\_\_\_

Lawyer’s address: \_\_\_\_\_

Street

City

State

Zip code

Which joint (s) are you having trouble with? (Please check all those that apply)

- Right side:  Shoulder    Elbow    Wrist    Hand    Fingers  
 Hip    Knee    Ankle    Foot    Toes

- Left side:  Shoulder    Elbow    Wrist    Hand    Fingers  
 Hip    Knee    Ankle    Foot    Toes

Back    Neck    Other (please specify) \_\_\_\_\_

Please circle your **one major** complaint and please check any **other complaints**.

Aching/Soreness

Limping

- |  |   |
|--|---|
| <input type="checkbox"/> Getting up from a chair | <input type="checkbox"/> Popping/Noises     |
| <input type="checkbox"/> Loss of activities      | <input type="checkbox"/> Loss of work       |
| <input type="checkbox"/> Back or neck pain       | <input type="checkbox"/> Leg or arm pain    |
| <input type="checkbox"/> Driving                 | <input type="checkbox"/> Reading            |
| <input type="checkbox"/> Sitting                 | <input type="checkbox"/> Sports are limited |
| <input type="checkbox"/> Numbness                | <input type="checkbox"/> Standing           |
| <input type="checkbox"/> Stiffness               | <input type="checkbox"/> Swelling           |

**Difficulty with:**  Lifting  Putting on clothes/shoes  Climbing/descending stairs  
 Loss of motion  Weakness  Walking

Please list any other complaints: \_\_\_\_\_

**Onset of the problem:**

**Suddenly** without known injury on \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_ Days ago \_\_\_\_ Weeks ago \_\_\_\_ Months ago \_\_\_\_ Years ago

Gradually since \_\_\_\_/\_\_\_\_/\_\_\_\_  I do not know when it started

**An injury** on \_\_\_\_/\_\_\_\_/\_\_\_\_  At work  Other (specify location) \_\_\_\_\_  
 \_\_\_\_ Days ago \_\_\_\_ Weeks ago \_\_\_\_ Months ago \_\_\_\_ Years ago

**Overall**, since it started, is your problem  getting worse or  Staying the same?

Have you missed work or practice because of your injury?  Yes  No

**Injured while:** (Please check all those that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Falling                       | <input type="checkbox"/> Hit by an object | <input type="checkbox"/> Throwing         |
| <input type="checkbox"/> Hit by another player         | <input type="checkbox"/> Lifting          | <input type="checkbox"/> Tripping         |
| <input type="checkbox"/> Non-contact                   | <input type="checkbox"/> Pulling/Pushing  | <input type="checkbox"/> Bending over     |
| <input type="checkbox"/> Reaching                      | <input type="checkbox"/> Twisting         | <input type="checkbox"/> Vehicle accident |
| <input type="checkbox"/> Other (please specify): _____ |   |   |

**Injured during:** (Please check all those that apply)

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Aerobics                      | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Baseball                      | <input type="checkbox"/> Bicycling  |
| <input type="checkbox"/> Football                      | <input type="checkbox"/> Handball   |
| <input type="checkbox"/> Racquetball                   | <input type="checkbox"/> Soccer     |
| <input type="checkbox"/> Running                       | <input type="checkbox"/> Skiing     |
| <input type="checkbox"/> Tennis                        | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Other (please specify): _____ |                                     |

**If this injury was on the job, please fill out this section.**

Injured at work on \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Was any equipment, machinery, and/or object involved in the accident?  Yes  No

If yes, please explain: \_\_\_\_\_

**Was the accident reported to your supervisor and/or employer at the time of the injury?**  Yes  No

**If this was a motor vehicle accident, please fill out this section.**

Vehicle accident on \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Were you (please check)?  Driver  Passenger  Pedestrian

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Were you wearing a seatbelt?  Yes  No

Did you strike your head or lose consciousness?  Yes  No

If you were a passenger, what was your position in the vehicle? \_\_\_\_\_

What kind of vehicle (s) was/were involved in the accident (Please circle your type of vehicle and check off the other)  Truck  Van  Car  Motorcycle  Other: \_\_\_\_\_

Type of collision:  Rear-ended  Head-on  T-type  Sideswipe  Struck on the left  
 Struck on the right  Multiple vehicles  "Daisy chain"  
 Other: \_\_\_\_\_

Was your vehicle moving when it was struck?  Yes  No How fast was it going? \_\_\_\_\_ mph.

Did your vehicle strike another vehicle or object?  Yes  No Describe:  
\_\_\_\_\_

Was the accident reported to the police?  Yes  No

Were traffic tickets issued?  Yes  No If yes, who received the tickets? \_\_\_\_\_

How was the weather? \_\_\_\_\_

Other: \_\_\_\_\_

**If you are experiencing PAIN, please answer this section.**

**If not, please circle NO PAIN and skip to the next page.**

**Location of the pain:** (Please check all those that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Neck only                  | <input type="checkbox"/> Back only                 | <input type="checkbox"/> Neck and back           |
| <input type="checkbox"/> Neck and arm/hand          | <input type="checkbox"/> Back and hip/leg          | <input type="checkbox"/> Between shoulder blades |
| <input type="checkbox"/> Arm/hand without neck pain | <input type="checkbox"/> Hip/leg without back pain | <input type="checkbox"/> Tailbone                |

**The pain goes to:** (Please check all those that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Back of the head           | <input type="checkbox"/> Tailbone               |
| <input type="checkbox"/> Shoulder                   | <input type="checkbox"/> Hip/buttocks           |
| <input type="checkbox"/> Between my shoulder blades | <input type="checkbox"/> Back of the thigh/knee |
| <input type="checkbox"/> Elbow                      | <input type="checkbox"/> Top of the foot        |
| <input type="checkbox"/> Back of the hand           | <input type="checkbox"/> Sole of the foot       |
| <input type="checkbox"/> Palm of the hand           | <input type="checkbox"/> Big toe                |

Where did your pain start? \_\_\_\_\_

Where did your pain spread to? (if anywhere) \_\_\_\_\_

Do you have any abnormal sensation? (Please check all those that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> None          | <input type="checkbox"/> Numbness       |
| <input type="checkbox"/> Tingling      | <input type="checkbox"/> Pins & needles |
| <input type="checkbox"/> Funny feeling | <input type="checkbox"/> Burning        |

Where? \_\_\_\_\_

Do you have weakness in the arms or legs?  Yes  No

Where? \_\_\_\_\_

Do you have any problems controlling your bowels or bladder?  Yes  No

**Frequency of pain:** (Please check all those that apply)

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Recent onset  | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Even when resting             |
| <input type="checkbox"/> Constantly    | <input type="checkbox"/> Irregularly  | <input type="checkbox"/> At work                       |
| <input type="checkbox"/> Unpredictable | <input type="checkbox"/> Every day    | <input type="checkbox"/> With or after activity/sports |
| <input type="checkbox"/> Most days     | <input type="checkbox"/> Some days    | <input type="checkbox"/> Mostly every night            |

Other: \_\_\_\_\_

**Time of day when the pain occurs?** (Please check all those that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Morning                         | <input type="checkbox"/> Unpredictable     | <input type="checkbox"/> At work          |
| <input type="checkbox"/> Late in the day                 | <input type="checkbox"/> Good and bad days | <input type="checkbox"/> All day/constant |
| <input type="checkbox"/> Interrupts my sleep             | <input type="checkbox"/> Evening           | <input type="checkbox"/> Irregular        |
| <input type="checkbox"/> No apparent pattern to the pain |  |   |

Other: \_\_\_\_\_

**The pain is:**

- |   |   |
|---|---|
| <input type="checkbox"/> Sharp/knifelike              | <input type="checkbox"/> Dull                         |
| <input type="checkbox"/> Aching                       | <input type="checkbox"/> Electric shock-like          |
| <input type="checkbox"/> Burning                      | <input type="checkbox"/> Continuous                   |
| <input type="checkbox"/> Worse in the morning         | <input type="checkbox"/> Worse in the evening         |
| <input type="checkbox"/> Increased by weather changes | <input type="checkbox"/> Worse with coughing/sneezing |

Other: \_\_\_\_\_

**Do you have stiffness in the back/neck?** (Please check all those that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> None                     | <input type="checkbox"/> Always                |
| <input type="checkbox"/> After activity or sports | <input type="checkbox"/> When sitting/driving  |
| <input type="checkbox"/> In the morning           | <input type="checkbox"/> At the end of the day |

Other: \_\_\_\_\_

**Have you had back or neck pain before?**  Yes  No When? \_\_\_\_\_

**What is the MAXIMUM amount of time you could sit in one place?**

- Less than 15 minutes  15-30 minutes  30-60 minutes  1-2 hours  Unlimited

**What is the MAXIMUM amount of time you could stand in one place?**

- Less than 15 minutes  15-30 minutes  30-60 minutes  1-2 hours  Unlimited

**What is the MAXIMUM distance you could walk?**

- From bed to wheelchair  Across the room  Less than 1 block  
 1-4 blocks  4 blocks to 1 mile  \_\_\_\_\_ miles/unlimited

**Which of the following aids for walking are you currently using?**

- No aids necessary  Brace  Cane  Crutches  Walker  Wheelchair

Could you go as far if you couldn't use an aid such as a cane or crutches?  Yes  No

**What is the MAXIMUM number of stairs that you can climb?**

- None  A few steps  ½ Flight  1 Flight  2 or more flights

**PLEASE CIRCLE THE NUMBER THAT CORRELATES BEST WITH HOW FAR YOU ARE FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOU CAN IMAGINE OR HAVE SUFFERED.**

0 = No pain or limitation at all.

10 = The worst possible pain or limitation that you could imagine

How bad is your pain today?	0 1 2 3 4 5 6 7 8 9 10
How bad is the pain at the worst it's ever been?	0 1 2 3 4 5 6 7 8 9 10
How bad is the pain at the best it's ever been?	0 1 2 3 4 5 6 7 8 9 10
Does the pain interfere with your lifestyle?	0 1 2 3 4 5 6 7 8 9 10
Does the pain interfere with your work?	0 1 2 3 4 5 6 7 8 9 10
Do you have pain lying in bed?	0 1 2 3 4 5 6 7 8 9 10

**Where is your pain?** (Please mark on the drawings where you feel the specific type of pain or sensation)

Use the following symbols to indicate your specific type of pain or sensation:

Burning: XXXX

Throbbing: +++++

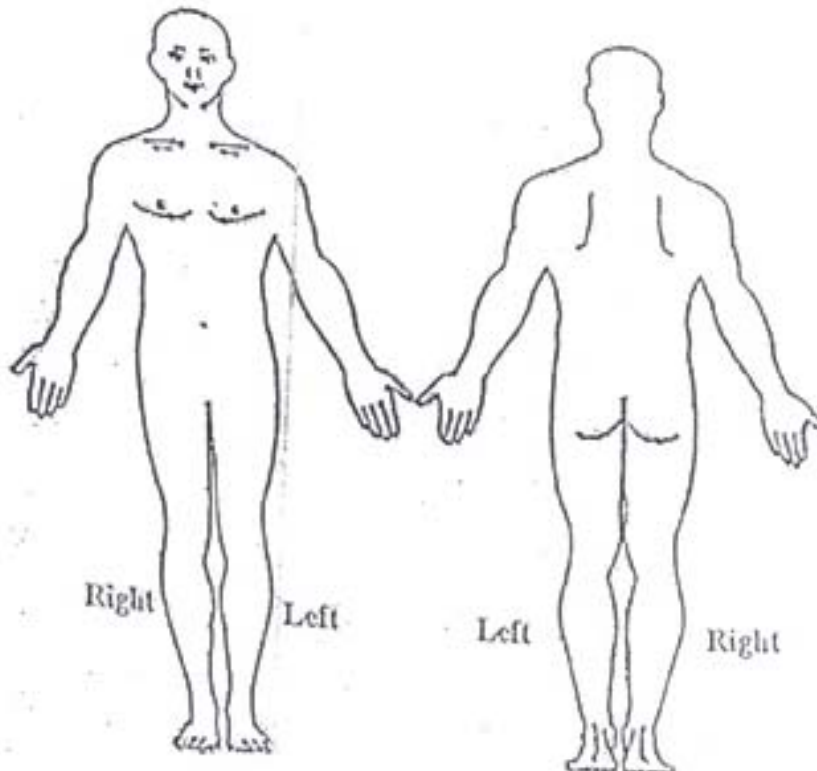
Sharp: ///

Aching: ●●●

Numbness: \*\*\*\*

**FRONT**

**BACK**



Next page please

**What activities or positions make the pain worse? (Please check all those that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Lifting/Reaching                           | <input type="checkbox"/> Pulling/Pushing               |
| <input type="checkbox"/> Lying down                                 | <input type="checkbox"/> Bending over                  |
| <input type="checkbox"/> Dressing/Putting on clothes                | <input type="checkbox"/> Putting on shoes/socks        |
| <input type="checkbox"/> Climbing up/downstairs                     | <input type="checkbox"/> Getting up from chair to walk |
| <input type="checkbox"/> Sitting (Driving, airplane, theater, etc.) | <input type="checkbox"/> Squatting/kneeling            |
| <input type="checkbox"/> Carrying things (laundry, groceries, etc.) | <input type="checkbox"/> Reading                       |
| <input type="checkbox"/> Walking                                    | <input type="checkbox"/> Standing                      |
| <input type="checkbox"/> Running/Jumping                            | <input type="checkbox"/> Twisting                      |
| <input type="checkbox"/> Yardwork/Housework                         | <input type="checkbox"/> Sexual activity               |
- Other: \_\_\_\_\_

**What activities or positions make the pain better? (Please check all those that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Nothing                | <input type="checkbox"/> Rest             | <input type="checkbox"/> Lifting         |
| <input type="checkbox"/> Activity/moving around | <input type="checkbox"/> Standing         | <input type="checkbox"/> Pulling/Pushing |
| <input type="checkbox"/> Heat                   | <input type="checkbox"/> Cold/ice         | <input type="checkbox"/> Lying down      |
| <input type="checkbox"/> Medicine               | <input type="checkbox"/> Sitting          | <input type="checkbox"/> Twisting        |
| <input type="checkbox"/> Wearing a brace        | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Bending         |
- Other: \_\_\_\_\_

**Have you taken any medication for the pain?  Yes  No (If so, please check all those that apply)****Pain medications**

- Darvocet-N-100 (propoxyphen)
- Tylenol #3 (with Codeine)
- Vicodin (hydrocodone)
- Percodan (oxycodone)
- Tylenol (acetaminophen)
- Ultram (tramadol)
- Duracet (bromfenac)

**Anti-inflammatories**

- Motrin/Ibuprofen/Advil
- Aspirin
- Naprosyn (naproxen)
- Voltaren (diclofenac)
- Feldene (piroxicam)
- Indocin (indomethacin)
- Prednisone
- Daypro (oxaprozin)
- Clinoril (sulindac)
- Lodine (etodolac)
- Relafen (nabumetome)
- Nalfon (fenoprofen)
- Trilisate (trisalicylate)
- Cortisone injection

**Muscle relaxants**

- Valium (Diazepam)
- Flexaril
- Skelaxin
- Soma (carisoprodal)
- Robaxin (methocarbamol)
- Dantrium (dantrolene)

**Does the medication help?  Yes  No  Only a little bit****Activities you CANNOT perform because of the injury? (Please check all those that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> None                        | <input type="checkbox"/> Climbing up/downstairs                     |
| <input type="checkbox"/> Lifting                     | <input type="checkbox"/> Sitting (driving, airplane, theater, etc.) |
| <input type="checkbox"/> Reaching                    | <input type="checkbox"/> Carrying things (groceries, laundry, etc.) |
| <input type="checkbox"/> Dressing/Putting on clothes | <input type="checkbox"/> Walking                                    |

Next page please

**Continued**

- |   |  |
|---|--|
| <input type="checkbox"/> Running/jumping        | <input type="checkbox"/> Getting up from a chair to walk |
| <input type="checkbox"/> Yardwork/housework     | <input type="checkbox"/> Squatting/kneeling              |
| <input type="checkbox"/> Pushing                | <input type="checkbox"/> Reading                         |
| <input type="checkbox"/> Pulling                | <input type="checkbox"/> Standing                        |
| <input type="checkbox"/> Bending                | <input type="checkbox"/> Twisting                        |
| <input type="checkbox"/> Putting on shoes/socks | <input type="checkbox"/> Sexual activity                 |
| <input type="checkbox"/> Other: _____           |  |

I have had to quit some nonsporting recreational activities that I enjoy (Please list) \_\_\_\_\_

---

**How often do you wake up at night or have difficulty going to sleep?**

- |   |   |
|---|---|
| <input type="checkbox"/> Never  | <input type="checkbox"/> Rarely/sometimes                               |
| <input type="checkbox"/> Most nights                                      | <input type="checkbox"/> Every night                                    |
| <input type="checkbox"/> I <b>can</b> sleep but only when I take medicine | <input type="checkbox"/> I <b>can't</b> sleep even when I take medicine |

**Which sports do you (or would like to) participate in but are limited in them?** \_\_\_\_\_

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**Have you or do you participate in competitive sports and at what level?** \_\_\_\_\_

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**Has your injury ever been treated by your family physician?**  Yes  No

Physician's name: \_\_\_\_\_ When? \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Treatment? \_\_\_\_\_

**Has your injury ever been treated by an orthopedic or neurosurgeon?**  Yes  No

Physician's name: \_\_\_\_\_ When? \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Treatment? \_\_\_\_\_

**Has your injury ever been treated by a chiropractor or naprapath?**  Yes  No

Physician's name: \_\_\_\_\_ When? \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Treatment? \_\_\_\_\_

**Were you ever treated for your injury in an emergency room?**  Yes  No

Hospital: \_\_\_\_\_ When? \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Treatment? \_\_\_\_\_

**Have you ever been admitted to a hospital for your injury?**  Yes  No

Hospital: \_\_\_\_\_ When? \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Treatment? \_\_\_\_\_

**Have you ever had physical therapy (PT), a brace, or a corset?**  Yes  No

When: \_\_\_\_\_ Where? \_\_\_\_\_  
 Results: \_\_\_\_\_

**Have you ever had x-rays of your injury taken?** Yes  No

When: \_\_\_\_\_ Where? \_\_\_\_\_

Results: \_\_\_\_\_

**Have you ever had a myelogram (dye test) done?** Yes  No

When: \_\_\_\_\_ Where? \_\_\_\_\_

Results: \_\_\_\_\_

**Have you ever had a CAT scan or an MRI of your injury done?** Yes  No

When: \_\_\_\_\_ Where? \_\_\_\_\_

Results: \_\_\_\_\_

**Have you ever had an EMG/NCVS (electromyogram/nerve conduction velocity) done?** Yes  No

When: \_\_\_\_\_ Where? \_\_\_\_\_

Results: \_\_\_\_\_ Ordering Doctor: \_\_\_\_\_

**Have you ever had a chymopapain injection (meat tenderizer)?** Yes  No

When: \_\_\_\_\_ Where? \_\_\_\_\_

Results: \_\_\_\_\_ Ordering Doctor: \_\_\_\_\_

**Have you ever had spine surgery (laminectomy or spinal fusion)** Yes  No

When: \_\_\_\_\_ Where? \_\_\_\_\_

Results: \_\_\_\_\_ Ordering Doctor: \_\_\_\_\_

**THANK YOU FOR YOUR PATIENCE IN FILLING OUT THIS FORM!**