Reconstructive Orthopaedic Center Therapy
Patient Medical Questionnaire

Patient's Name: _____ Date: _____

Social History/Education History:

Occupation: _____ Currently Employed? ( ) Yes ( ) No

Work Requirements: _____

Any work restrictions? ( )Yes ( ) No What are they? _____

Where you working before your injury? ( ) Yes ( ) No

What type of home do you live in?
( ) Single Family Home
( ) Apartment
( ) Assisted Living
( ) Nursing Home

Do you have any of the following in your home?
( ) Stairs with railings; How many stairs to enter the home? ___
( ) Stairs without railings
( ) Ramps
( ) Elevators

Do you live alone? ( ) Yes ( ) No Are you able to drive? ( ) Yes ( ) No

Do you have a regular exercise program? ( ) Yes ( ) No
If yes, what type of program and how frequently?

_____

_____

The following information is necessary in order to improve the quality of service you receive during your therapy visits. Please complete all questions.

Have you had a nurse or a therapist come to your home/place of residence to treat you for any of the following:

a) Bathing ( ) Yes ( ) No
b) Dressing ( ) Yes ( ) No
c) Wound Care ( ) Yes ( ) No
d) Exercises ( ) Yes ( ) No
e) Anything ( ) Yes ( ) No

Is someone still coming to your house for any of the above? ( ) Yes ( ) No

If yes, then who _____?

Please check the following medical conditions that apply.

	Heart Disease		Asthma		Depression
	Diabetes		Bleeding Disorder		Broken Bones
	Vision Problems		Epilepsy/Seizures		Joint replacement
	Hearing Problems		Hepatitis		Upper Limb Amputation
	High Blood Pressure		HIV/AIDS		Overweight, Obesity
	Allergies		Arthritis		Dementia
	Other:				

Have you had any therapy prior to today for your current problem? ( ) Yes ( ) No

If yes, then where? _____ How long? _____

Please make a check mark below next to the activities that are being affected by your current condition.

Positions:
( ) Sitting
( ) Working at a computer
( ) Standing
( ) Resting on stomach
( ) Resting on back
( ) Lie on right side
( ) Lie on left side

Personal Hygiene:
( ) Shaving
( ) Brush teeth
( ) Comb/blow dry hair
( ) Taking shower/bath
( ) Put on deodorant
( ) Stepping into shower/tub
( ) Transferring on/off toilet

Dressing:
( ) Pull shirt on/off
( ) Put on socks/shoes
( ) Fasten bra (if applicable)

Lifting:
( ) Able to squat to floor
( ) Lift from the floor to waist
( ) Lift overhead
( ) Lift a gallon of milk/water
( ) Lifting/carrying children
( ) Lift a glass or plate

Driving:
( ) Open & closing car door
( ) Turning steering wheel
( ) Turning head/neck
( ) Shifting gears
( ) Pull seatbelt over to buckle
( ) Get in/out of car
( ) Turn ignition key

Walking:
( ) Walking
( ) Walk up stairs
( ) Walk down stairs
( ) Walk up & down curb

Fine Motor:
( ) Writing
( ) Sewing
( ) Button shirt/pants

Household Activities:
( ) Sweeping
( ) Vacuuming
( ) Load/unload dishwasher
( ) Laundry
( ) Mopping
( ) Dusting
( ) Cooking

Yard Work:
( ) Mow lawn
( ) Gardening
( ) Raking
( ) Sweeping

Other:
( ) Turning door knobs
_____
_____
_____

PAIN SCALE:

We will ask you to grade your pain on a scale of 0 to 10.
We would like to inform you that we will be asking you what your pain leave is prior to beginning a treatment, as well as during and following treatment.

0 = NO PAIN / 10 = WORST PAIN IN YOUR LIFETIME or you feel you have to go to the emergency room.

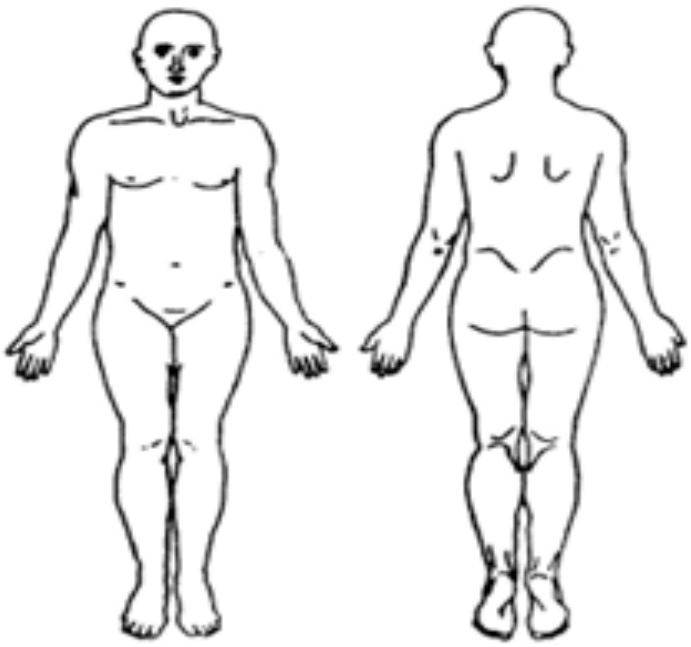
Circle where you would rank you pain right **NOW**:
0 1 2 3 4 5 6 7 8 9 10

What is the **BEST** your pain has been over the past two weeks?
0 1 2 3 4 5 6 7 8 9 10

What is the **WORST** your pain has been over the past two weeks?
0 1 2 3 4 5 6 7 8 9 10

Mark your symptoms on the body diagram:

Severe Pain	XXXXXXXX
Moderate Pain	///////////
Tingling	++++++++
Numbness	OOOOOO
Shooting Pain	----------



How severe is your pain?

Circle the number pain that best describes your pain where: 0 = no pain and 10 = the worst pain.

At its worst?	0	1	2	3	4	5	6	7	8	9	10
When lying on the involved side?	0	1	2	3	4	5	6	7	8	9	10
Reaching for something on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Touching the back of your neck?	0	1	2	3	4	5	6	7	8	9	10
Pushing with the involved arm?	0	1	2	3	4	5	6	7	8	9	10

FUCTIONAL SCALE

Please check the level of difficulty you have performing the following tasks?

Difficulty level	**No Difficulty**	**Mild Difficulty**	**Moderate Difficulty**	**Severe Difficulty**	**Unable to**
Washing your hair?					
Washing your back?					
Putting on an undershirt or jumper?					
Putting on a shirt that buttons down the front?					
Putting on your pants?					
Placing an object on a high shelf?					
Carrying a heavy object of 10 pounds?					
Removing something from your back pocket?					

Patient Signuature: _____ Date:_____