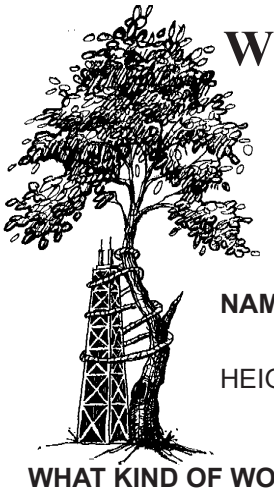


WINDY CITY ORTHOPEDICS & SPORTS MEDICINE

2617 W. Peterson Avenue Chicago, Illinois 60659
Toll Free 877-549-4490 Suburban 847-475-0200 Chicago 773-743-1981

TODAY'S DATE _____/_____/_____

PATIENT INFORMATION QUESTIONNAIRE: INJURY

NAME _____
FIRST MIDDLE LAST

HEIGHT _____ WEIGHT _____ AGE _____

I AM RIGHT HANDED **I AM LEFT HANDED** (Please Circle)

WHAT KIND OF WORK DO YOU DO? (Please Circle) Construction Desk Job Driving Teacher

Executive/Professional Factory Homemaker Retired Sales Student

Other (Please List) _____

IF YOU ARE <u>NOT</u> WORKING NOW, WHEN DID YOU LAST WORK? _____/_____/_____

DOES IT REQUIRE LIFTING? **HOW OFTEN DO YOU LIFT THESE WEIGHTS?** (Please Circle)

None 10 lbs. or less 10-50 lbs. 50-100 lbs More than 100 lbs.

Rarely Frequently Constantly

AS PART OF YOUR WORK DO YOU COMMONLY? (Please Circle All Those That Apply)

Squat Push Pull Lift Overhead Climb Ladders/Stairs Reach Bend Stoop

IS THIS A WORKMAN'S COMPENSATION CASE? (Please Circle) Yes No

Company Name _____ Company Phone (_____)_____

Company Address _____
STREET CITY STATE ZIP

IS THIS A LEGAL OR THIRD PERSON LIABILITY CASE? (Please Circle) Yes No

Lawyer's Name _____ Lawyer's Phone (_____)_____

Lawyer's Address _____
STREET CITY STATE ZIP

WHICH JOINT(S) ARE YOU HAVING TROUBLE WITH? (Please Circle Those That Apply)

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

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

Neck Back Left Buttock Right Buttock Left Groin Right Groin Left Thigh Right Thigh

Other (Please List) _____

_____

PLEASE <u>CIRCLE</u> YOUR <u>ONE MAJOR</u> COMPLAINT! PLEASE <u>CHECK</u> (✔) ANY OTHER COMPLAINTS

Pain/Aching/Soreness	Limping	Getting Up From a Chair
Popping/Noises	Loss of Activities	Loss of Work
Back or Neck Pain	Leg or Arm Pain	Driving
Reading/Sitting	Sports/Running are Limited	Numbness in the Arms or Legs
Standing	Stiffness	Deformity/Spinal Curvature

Difficulty With: Lifting Putting on Clothes/Shoes Stairs Loss of Motion Weakness Walking

Any Other Complaints _____

_____

HAVE YOU EVER HAD A SIMILAR INJURY OR PAIN BEFORE? YES NO

WHEN?_____

_____

ONSET OF THE PROBLEM:

Suddenly But **No Known Injury:** On ____/____/____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

An Injury : On ____/____/____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

I Don't Know When _____ Gradually Since _____

Other_____

HAVE YOU MISSED WORK/PRACTICE BECAUSE OF YOUR PROBLEM? Yes No

How long have you been off work? ____ days ____weeks ____ months _____ Since the Injury

If you have returned to work, when did you return? ____week(s) ago ___ month(s) ago On ____/____/____

HAVE YOU BEEN ON LIGHT OR LIMITED DUTY BECAUSE OF YOUR PROBLEM? Yes No

INJURED WHILE:(Please Circle All Those That Apply)

Falling	Hit By Object	Lifting	Hit By Another Player
Tripping/Noncontact	Pulling/Pushing	Reaching	Slipped on Ice/Water/Oil
Twisting	Vehicle Accident	Running/Jumping	

Other_____

INJURED DURING:(Please Circle)

Aerobics	Basketball	Baseball	Bicycling
Football	Handball	Racquetball	Running
Soccer	Skiing	Tennis	Volleyball

Other _____

AT THE TIME OF THE INJURY, DID YOU FEEL OR HEAR A RIP, POP OR TEAR? Yes No

---

IF THIS WAS AN INJURY ON THE JOB, PLEASE FILL OUT THIS SECTION

Injury At Work On _____ Time of Day _____ 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 of Day _____ AM PM

Were You? (Please Circle) Driver Passenger Pedestrian Wearing a Seatbelt? **Yes** **No**

Did you strike your head or lose consciousness? **Yes** **No**

If you were 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 place a check (✔) over the other) Truck Van Car Motorcycle

Other _____

Was the collision?: Rear end Headon "T" Type Sideswipe Struck on the Left Struck on the Right

Multiple Vehicle "Daisy Chain" Other _____

_____

Was your vehicle moving when it was struck? **Yes** **No** How fast was it going? _____

Was the accident reported to the police? **Yes** **No**

What was the weather? _____

Did your vehicle strike another vehicle or object? **Yes** **No** Please Describe: _____

_____

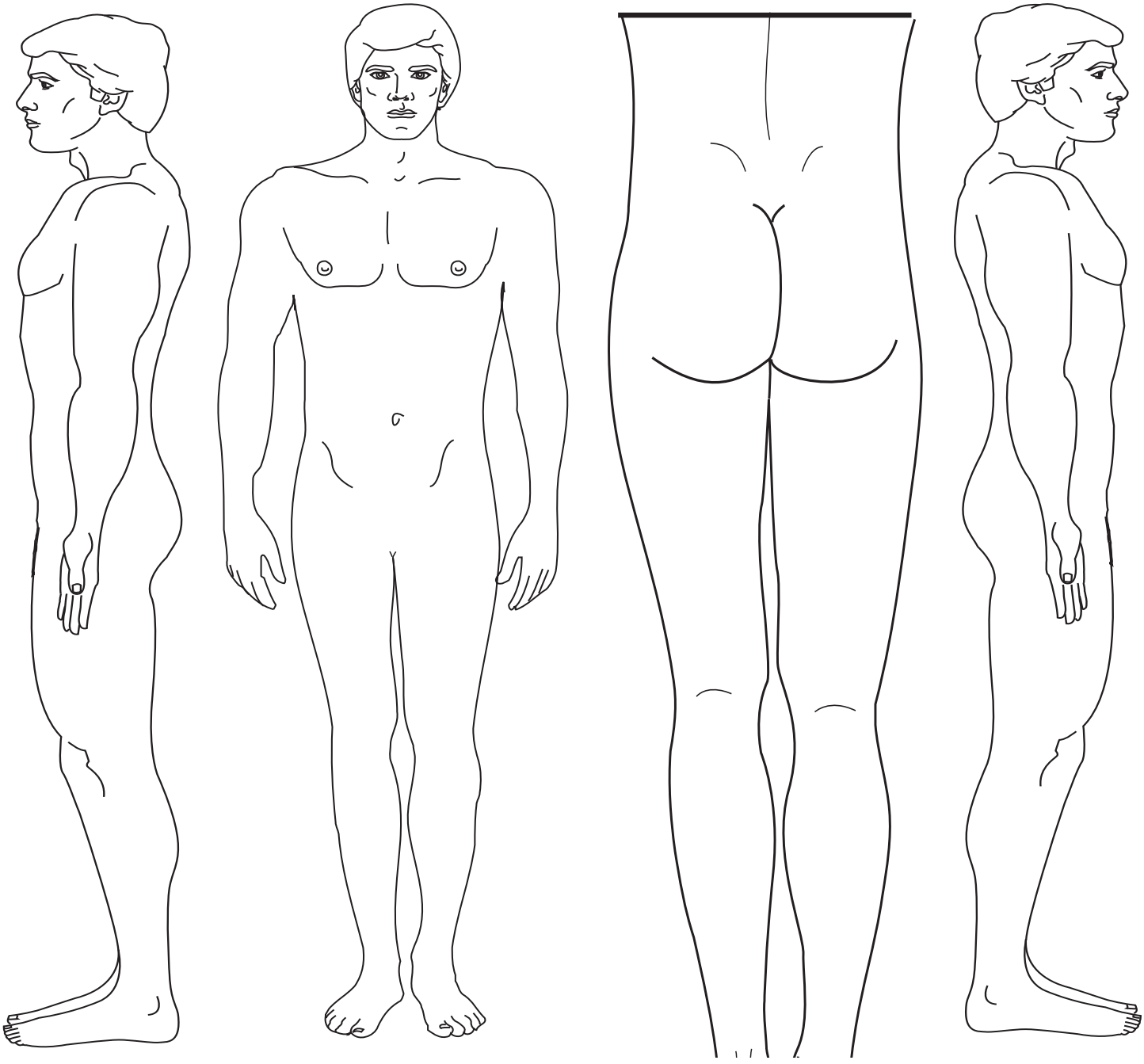
Other _____

_____

WHERE IS YOUR PAIN? (Please mark on the drawings where you feel the specific type pain or sensation)

Burning [XXXX] Throbbing [✔✔✔✔] Sharp [//////////] Aching [●●●●●] Numbness [✳✳✳✳]

LEFT **FRONT** **BACK** **RIGHT**



HAVE YOU TAKEN ANY MEDICATIONS FOR THIS PROBLEM? **YES** **NO**

(Please Circle Your CURRENT Medications and Check (✔) Any OthersThat You Have Taken in the Past)

Pain Medication	Antiinflammatory Drugs		Muscle Relaxants/Neuro Drugs
Tylenol (acetaminophen)	Aspirin	Daypro(oxaprozin)	Flexeril (cyclobenzaprene)
Tylenol #3 (codeine)	Motrin/Ibuprofen/Advil	Clinoril (sulindac)	Neurontin (gabapentin)
Vicodin/Norco (hydrocodone)	Naprosyn(Aleve)	Lodine(etodolac)	Lyrica(pregabalin)
Oxycontin/Oxycodone	Celebrex (celecoxib)	Limbrel	Soma (carisoprodal)
Percodan (oxycodone)	Mobic (meloxicam)	Indocin(indomethacin)	Dantrium(dantrolene)
Darvocet-N-100(propoxyphene)	Voltaren(diclofenac)	Relafin(nabumetone)	Robaxin(methocabamol)
Ultram (tramadol)	Feldene (piroxicam)	Nalfon (fenoprofen)	Skelaxin(metaxalone)
Duract (bromfenac)	Trilisate (trisalicylate)	Glucosamine	Requip (ropinorole)

Other _____

Have you ever had a Cortisone injection or a Prednisone/Medrol dose pack? Yes No How Many? 1 2 3 4 5 >5

Do you use any Herbal Medicine? _____

DOES THE MEDICATION HELP? Yes No Only A Little Bit

WERE YOU TREATED FOR THIS PROBLEM BY YOUR FAMILY PHYSICIAN? YES NO

Name_____ When _____

Diagnosis _____ Treatment _____

WERE YOU TREATED FOR THIS PROBLEM BY AN ORTHOPEDIC OR NEUROSURGEON? YES NO

Name_____ When _____

Diagnosis_____

WERE YOU TREATED FOR THIS PROBLEM IN AN EMERGENCY ROOM? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

WERE YOU EVER ADMITTED TO THE HOSPITAL FOR THIS PROBLEM? YES NO

Hospital _____ When _____

Diagnosis _____ Treatment _____

HAVE YOU EVER HAD SURGERY FOR THIS PROBLEM? YES NO

When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

WERE YOU TREATED FOR THIS PROBLEM BY A CHIROPRACTER OR NAPROPATH? YES NO

Name_____ When _____

Diagnosis _____ Treatment _____

DID YOU EVER HAVE X-RAYS TAKEN FOR YOUR PROBLEM? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

DID YOU HAVE A CAT SCAN OR MRI DONE FOR THIS PROBLEM? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

DID YOU HAVE AN EMG/NCV DONE? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

HAVE YOU EVER HAD PHYSICAL THERAPY (PT), A CORSET OR A BRACE? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____