Webster Orthopedics
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Kevin M. Roth, MD
Orthopedic Surgeon
Sports Medicine / Fracture Care

INTAKE QUESTIONNAIRE

(Please fill out ONE form per body part you would like the doctor to examine, and do your best to answer all questions below)

Last Name _____ First Name _____ Your Age _____ Today's Date ____ /____ /___
Email Address _____
Primary Care Physician _____
Are you right handed or left handed? (Please circle) **RIGHT** **LEFT** **AMBIDEXTROUS**
How likely do you feel it is that your current musculoskeletal problem will require surgery? (Please circle one)
NOT AT ALL **UNLIKELY** **I DON'T KNOW** **SOMEWHAT LIKELY** **VERY LIKELY**

Information regarding your current musculoskeletal problem:
When did your *current problem* begin? _____/_____/_____
What body part is your *current problem* _____
Is your problem to the (please circle): **RIGHT SIDE** **LEFT SIDE** **BOTH SIDES**
Work related injury? **YES** **NO**
If YES, date injury reported _____ /____ /_____
Are you currently able to work? **YES** **NO**
If YES, what is your current profession? _____

Please describe your *current problem* and *how it started*:
_____
_____
_____

Please circle answers below:

1. Do you currently have pain? **YES** **NO** **(If "yes," please answer questions a-g below, otherwise please skip to question #2 on the next page)**
   a. WHERE on this body part is your pain located?
      FRONT **BACK** **INSIDE** **OUTSIDE** **ALL OVER**
   b. Please list the average intensity of your pain on a scale of 1 – 10 over the past 7 days:
      1 2 3 4 5 6 7 8 9 10
   c. How often do you experience pain from your *current problem*?
      RARELY **FREQUENTLY** **CONSTANTLY**
   d. Does your pain allow you to sleep at night? **YES** **NO**
   e. Is there anything that helps to alleviate your pain from your *current problem*?
      _____
   f. Is there anything that makes your pain from your *current problem* worse?
      _____
   g. Do you ever take pain medication for your pain? **YES** **NO**
      If YES, please list: _____

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2. Was this a result of an injury? **YES** **NO**
3. Was the onset: **GRADUAL** **SUDDEN**
4. Does your joint feel unstable? **YES** **NO**
5. Do you experience any of the following? (Please circle):
   CLICKING **CATCHING** **LOCKING** **GRINDING** **DISLOCATION**
   WEAKNESS **NUMBNESS** **TINGLING**
6. Is your *current problem* getting: **WORSE** **BETTER** **STAYING THE SAME**
7. Date and results if known of imaging studies performed for your *current problem*:
   a. Xrays: _____ b. CT scan: _____.
   c. MRI: _____ d. EMG: _____
   e. Other _____
8. Have you had any of the following non-operative treatment to date for your *current problem*:
   a. Physical Therapy: **YES** **NO**
      If YES, duration and response to PT: _____
   b. Acupuncture: **YES** **NO**
      If YES, duration and response to Acupuncture: _____
   c. Chiropractic Manipulation: **YES** **NO**
      If YES, duration and response to Chiropractics: _____
   d. NSAIDs (e.g. Advil, Aleve, etc.) : **YES** **NO**
      *If YES, name of NSAID and response to NSAID:*_____
   e. Cortisone injections: **YES** **NO**
      If YES, date(s) and response to cortisone injections: _____
   f. Other Injections (e.g. Synvisc, PRP): **YES** **NO**
      If YES, duration and response to other injections: _____
   g. Have you had any surgical procedures for your *current problem*?: **YES** **NO**
      If YES, please provide dates, procedure description and surgeon name.
      Date: ___/___/___ Procedure: _____ MD Name: _____
      Date: ___/___/___ Procedure: _____ MD Name: _____
      Date: ___/___/___ Procedure: _____ MD Name: _____

9. Please list the sorts of activities that you enjoy doing which you are currently unable to do (e.g. walking, running, rock climbing, football, tennis, golf, etc.):
   _____
   _____

Please list any additional information that you feel would be important for us to know regarding your condition including what your specific goals and expectations are related to your treatment outcomes:

_____

_____