NYU Langone
MEDICAL CENTER

NYU Langone Seaport Orthopaedics
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INITIAL PATIENT QUESTIONNAIRE

Patient's Name _____ Date of Exam _____

Social Security Number _____ Date of Birth _____

Gender: ◻ Male ◻ Female Are You: ◻ Right Handed ◻ Left Handed Age _____

Information Source: _____ Patient
_____ Records

DETAILS OF THE ACCIDENT/ INJURY

1. Date of Accident/Injury: _____
2. Type of Claim:
   ◻ Motor vehicle accident,
   Were you: ◻ Driver ◻ Passenger ◻ Pedestrian ◻ Motorcyclist ◻ Bicyclist
   Were you wearing a seatbelt? ◻ No ◻ Yes

   ◻ Work related accident/injury,
   Was a report filled out by the employer? ◻ No ◻ Yes
3. Please explain in detail how accident/ injury occurred. _____
4. Areas of injury: ◻ Head ◻ Neck ◻ Back ◻ Other _____
5. Did you lose consciousness? ◻ No ◻ Yes: For how long? _____

IMMEDIATE CARE POST INJURY

6. Did you go to an emergency room (E.R.)? ◻ No ◻ Yes
   If yes: name of E.R. _____
   Date: _____
7. In E.R., were x-rays taken? ◻ No ◻ Yes
   If yes, what was x-rayed? _____
   Results: _____

Numbness	Pins and Needle	Burning	Stabbing	Aching
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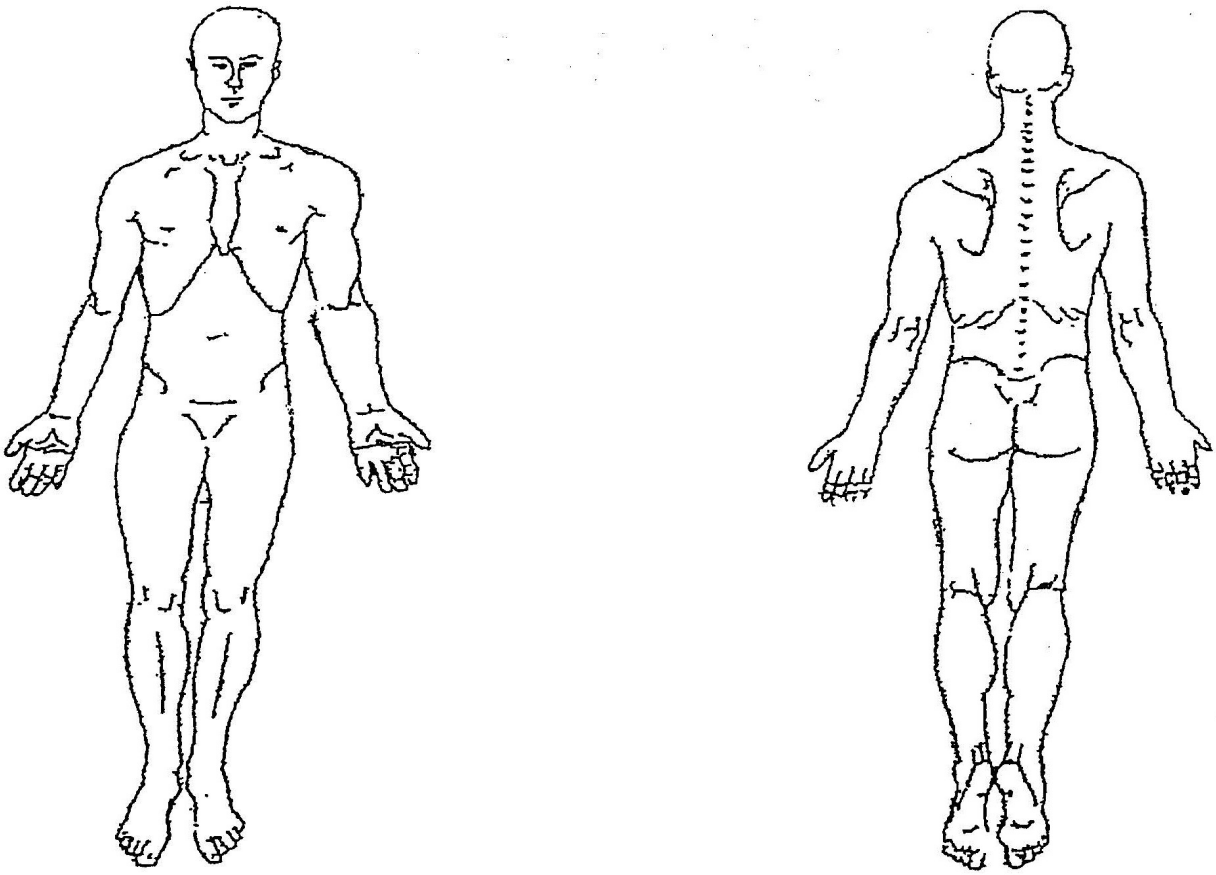
RIGHT LEFT LEFT RIGHT



On the line below please indicate (with an X) how severe your pain is now.

No Pain _____ Worst Possible Pain

0 -1 -2 -3 -4 -5 -6 -7- 8– 9 -10

Is your pain constant? Yes No

Is your pain intermittent? Yes No

If yes, how frequent? _____

8. What other treatment did you receive in E.R.?
   □ Medication □ Cane □ Crutches □ Arm sling □ Ace bandage □ Splint □ Cast □ Neck collar
   □ Brace □ Other _____

9. Were you admitted overnight to a hospital? □ No □ Yes, how many days? _____
   What is the name of Hospital? _____

10. Did you require surgery? ◻ No ◻ Yes, what procedure? _____

_____

11. Since the accident, has your pain: ◻ Increased ◻ Decreased ◻ Not changed

PREVIOUS TREATMENT FOR THIS INJURY

12. A. List all doctors seen since accident/injury: ◻ None

Specialty	Name of Doctor	Specialty	Name of Doctor
◻ Orthopaedist	_____	◻ Neurologist	_____
◻ Neurosurgeon	_____	◻ TMJ/ Dentist	_____
◻ Chiropractor	_____	◻ Physiatrist	_____
◻ Podistrist	_____	◻ Internal Medicine	_____

◻ Other _____

B. Were additional tests (x-rays, scans, EMG, etc.) taken? ◻ No ◻ Yes, what tests?

◻ X-ray of the	_____	◻ MRI of the	_____
◻ CT scan of	_____	◻ SSEP of the	_____
◻ EMG of the	_____	◻ EEG of the	_____

◻ Other _____

13. What did doctors treat you with ? ◻ Medication ◻ Physical Therapy ◻ Pool Therapy ◻ Heat ◻ Surgery
◻ Chiropractic treatment ◻ Ultrasound ◻ Acupuncture ◻ Epidural Steriod Inj. ◻ Trigger Point Inj.
◻ Facet Inj. ◻ Other _____
◻ Joint injections: Knee (R / L) Elbow (R / L) Shoulder (R / L) Foot/ Ankle (R / L)
Hip (R / L)

14. What were the results of the above treatment?
◻ No help ◻ Complete relief ◻ Partial relief

15. What activities make your pain worse? (please X all that apply) ◻ None
◻ Lying ◻ Standing ◻ Exercise ◻ Twisting ◻ Sitting ◻ Walking ◻ Bend Fwd
◻ Bend backward ◻ Early Morning ◻ End of Day ◻ Other_____

16. Does your pain limit your ability to the following?
□ Lift □ Standing □ Carry □ Walk □ Run □ Climb Stairs □ Exercise □ Wear high heels
□ Do overhead activities □ Reach behind your back

17. Does you pain cause any of the following? (please X all that apply) □ None
□ Weakness □ Sleep disturbances □ Sexual dysfunction

18. Is you sleep affected by pain? □ No □ Yes
If yes: Do you have problem falling asleep? □ No □ Yes
Do you awake in the night due to pain? □ No □ Yes
Do you require medication to sleep? □ No □ Yes

19. What reduces your pain? (please X all that apply) □ None
□ Lying □ Standing □ Exercise □ Twisting □ Sitting □ Walking □ Rest
□ Heat/Cold □ Pain Meds □ Massage □ P.T. □ Weather change
□ Other _____

20. Associated symptoms for shoulder, elbow, wrist, hand, hip, knee, and foot/ankle.

Is there: □ clicking □ buckling/ giving way □ snapping □ cracking □ popping □ fatigue

Does the pain radiate? □ Yes □ No

If yes, to where? _____

21. Do you need assistance with the following?

□ Clean □ Cook □ Shop □ Toileting □ Bath/Shower □ Dressing

□ Grooming □ Other: _____

22. How did you arrive to the office today? _____
Can you take public transportation? □ No □ Yes

PREVIOUS INJURY

23. Have you ever had similar injuries or complaints previous to this injury? □ No □ Yes
If yes, what area of the body was previously injured and dates/of previous injury? _____
_____
_____

Treating Doctor: _____

24. What treatment were you given for the previous injury? □ None
□ Chiropractic Treatment □ Bracing □ Injection □ Medication □ Physical Therapy
□ Surgery □ Other _____

25. Did you fully recover from this injury? □ No □ Yes

PAST MEDICAL HISTORY/ REVIEW OF SYSTEM

26. Have you ever been admitted to a Hospital for medical reasons? ☐ No ☐ Yes
If yes, what was the medical reason? _____

Please X any illnesses or problems that apply to you. ☐ None

☐ Heart condition
☐ Liver disease/ Hepatitis
☐ Mental illnesses
☐ Stroke
☐ Bleeding/bruising
☐ Thyroid
☐ Prostate disease
☐ Kidney disease
☐ Diabetes (Type I or II)
☐ Bowel trouble
☐ Skin rashes/lesions
☐ Asthma/Emphysema
☐ Cancer
☐ Other medical problems- what kind? _____
☐ High blood pressure
☐ Ulcers/Reflux
☐ Gall bladder disease
☐ Epilepsy/seizures
☐ Sickle cell anemia
☐ Arthritis- what type?

PAST SURGICAL HISTORY

Please X any illnesses or problems that apply to you. ☐ None

☐ Lumbar spine/back
☐ Cervical spine/back
☐ Thyroid
☐ Breast
☐ Tonsils
☐ Appendectomy
☐ Cyst/ tumor surgery
☐ Ulcer surgery
☐ Knee RT or LT
☐ Shoulder RT or LT
☐ Lung
☐ Heart
☐ Liver
☐ Kidney
☐ Hernia
☐ Tubal Ligation
☐ Cesarean section
☐ Stomach
☐ Hip RT or LT
☐ Wrist RT or LT
☐ Appendix
☐ Bowel/Hemorrhoid
☐ Gall Bladder surgery
☐ Uterus/Ovary/GYN
☐ Prostate
☐ Fracture correction
☐ Hysterectomy
☐ Other _____
☐ Elbow RT or LT
☐ Hand RT or LT

ALLERGIES

Please X any illnesses or problems that apply to you. ☐ None Known

☐ Penicillin ☐ Sulfa ☐ Iodine
☐ Other antibiotics or medications, food or dyes: _____
Do you have any difficulty taking anti-inflammatory medications? ☐ No ☐ Yes

MEDICATIONS CURRENTLY TAKING

Please list name of drug(s), dosage and how often ☐ None

_____ _____

_____ _____

FAMILY HISTORY

Please X any disease diagnosed in your blood relatives

◻ Cancer	◻ Diabetes	◻ Bleeding problems
◻ Heart Disease	◻ Sickle Cell Anemia	◻ Thyroid disease
◻ Hypertension	◻ ↑ Cholesterol	◻ Other_____

SOCIAL HISTORY

Please X all that apply to you.

Tobacco use: ◻ No ◻ Yes If yes, packs per day _____ # of years of use _____
Alcohol use: ◻ No ◻ Yes If yes, amount per week _____
None prescribed medications or recreational drugs: _____ ◻ None

28. Who do you live with? ◻ Husband ◻ Wife ◻ Son(s) ◻ Daughter(s) ◻ Family ◻ Parents
◻ Roommate ◻ Alone

29. Do you live in an : ◻ Apartment ◻ Room ◻ House ◻ Private home ◻ Other _____

30. Does your building have an elevator? ◻ Yes ◻ No, how many flight of stairs?_____

WORK HISTROY (MUST BE FILLED OUT)

31. Were you employed at the time of the accident? ◻ No ◻ Yes
If yes, please give us your job title and briefly describe your description and it's requirements.

Job Title: _____

Job description and requirements: _____

_____

_____

32. Have you missed any time from work because of this injury? ◻ No ◻ Yes
If yes, how long? _____

33. Are you presently working? ◻ No ◻ Yes
If no: When was the last day you worked? _____