Physical Medicine Questionnaire Dr. Gupta

Thank you in advance for completing this questionnaire. This information

1. will be helpful in understanding your condition and providing advice on your care
2. will be kept confidential and become part of your health record
3. may be used for monitoring of clinical care and outcomes

Please note:

1. **Take breaks**!
2. Please print the questionnaire and bring it to your visit – **DO NOT EMAIL or FAX IT**
3. Once English version of the questionnaire is validated we will develop a French version. Sorry for any inconvenience but translation can be done through google translate or chrome web browser

Issue

Issue # 1: Click here to enter text.

History & 0nset of Issue	
Made Worse by	
Made Better by	
Other related symptoms/problems	Click here to enter text.
Mechanism	☐Work Accident ☐Operations ☐Training ☐Domestic ☐Motor Vehicle Collision ☐Accident at Home ☐Sports Accident
Comments	

Musculoskeletal system Review of Systems

For Each Problem Area – Identify other Non Pain symptoms that are occurring as well – You only have to fill out the section for the joint region where you are having pain

Cervical Spine	☐ Catching ☐ Clicking ☐ Frozen or stuck ☐ Cracking/grinding ☐ Stiffness ☐ Not stable	☐ Weakness ☐ Numbness ☐ Other:	Associated issues with: ☐ Looking up ☐ Posture ☐ Helmet ☐ Backpack/rucksack ☐ Sitting at a desk ☐ Looking at a screen ☐ Driving ☐ Walking ☐ Running ☐ Other:	Are you having trouble with: ☐ Personal Care/Self Care ☐ Domestic Work ☐ Yard and House Maintenance ☐ Work ☐ Exercise ☐ Sleep ☐ Other:
Shoulder	☐ Catching ☐ Clicking ☐ Frozen or stuck ☐ Dislocation/unstable or coming out of socket	☐ Weakness ☐ Numbness ☐ Swelling ☐ Cracking or grinding ☐ Other:	Associated issues with: ☐ Sleeping ☐ Reaching ☐ Throwing ☐ Pushing ☐ Pulling ☐ Pushups ☐ Lifting overhead ☐ Carrying ☐ Other:	Trouble with: ☐ Personal Care/Self Care ☐ Domestic Work ☐ Yard and House Maintenance ☐ Work ☐ Exercise ☐ Sleep ☐ Other:
Elbow	☐ Catching ☐ Clicking ☐ Frozen or stuck ☐ Dislocation/unstable or coming out of socket	☐ Weakness ☐ Numbness ☐ Swelling ☐ Cracking or grinding ☐ Other:	Associated issues with: ☐ Sleeping ☐ Reaching ☐ Throwing ☐ Pushing ☐ Pulling ☐ Pushups ☐ Lifting overhead ☐ Carrying ☐ Leaning/pressure ☐ Other:	Trouble with: ☐ Personal Care/Self Care ☐ Domestic Work ☐ Yard and House Maintenance ☐ Work ☐ Exercise ☐ Sleep ☐ Other:
Wrist/Hand	☐ Catching ☐ Clicking ☐ Frozen or stuck ☐ Dislocation/unstable or coming out of socket	☐ Weakness ☐ Numbness ☐ Swelling ☐ Cracking or grinding ☐ Other:	Associated issues with: ☐ Sleeping ☐ Reaching ☐ Gripping ☐ Leaning/pressure ☐ Dexterity issues/dropping items ☐ Other:	Trouble with: ☐ Personal Care/Self Care ☐ Domestic Work ☐ Yard and House Maintenance ☐ Work ☐ Exercise ☐ Sleep

				☐ Other:
Low Back	☐ Catching ☐ Clicking ☐ Frozen or stuck ☐ Cracking/grinding ☐ Stiffness ☐ Not stable	☐ Weakness ☐ Numbness ☐ Other:	Associated issues with: ☐ Bending ☐ Leaning Back ☐ Twisting ☐ Sneezing/Coughing ☐ Posture ☐ Backpack/rucksach ☐ Sitting at a desk ☐ Standing ☐ Driving ☐ Shoveling ☐ Walking ☐ Running ☐ Stairs ☐ Other:	Trouble with: ☐ Personal Care/Self Care ☐ Domestic Work ☐ Yard and House Maintenance ☐ Work ☐ Exercise ☐ Sleep ☐ Other:
Hip/Groin	☐ Catching ☐ Clicking ☐ Frozen or stuck ☐ Dislocation/unstable or giving way	☐ Weakness ☐ Numbness ☐ Swelling ☐ Cracking or grinding ☐ Other:	Associated issues with: ☐ Stairs ☐ Twisting ☐ Squatting ☐ Sleeping on that side ☐ Walking ☐ Running ☐ Sitting	Trouble with: ☐ Personal Care/Self Care ☐ Domestic Work ☐ Yard and House Maintenance ☐ Work ☐ Exercise ☐ Sleep ☐ Other:
Knee	☐ Catching ☐ Clicking ☐ Frozen or stuck ☐ Dislocation/unstable or giving way	☐ Weakness ☐ Numbness ☐ Swelling ☐ Cracking or grinding ☐ Other:	Associated issues with: ☐ Stairs ☐ Twisting ☐ Squatting ☐ Sleeping on that side ☐ Walking ☐ Running ☐ Sitting	Trouble with: ☐ Personal Care/Self Care ☐ Domestic Work ☐ Yard and House Maintenance ☐ Work ☐ Exercise ☐ Sleep ☐ Other:
Foot/Ankle	☐ Catching ☐ Clicking ☐ Frozen or stuck ☐ Dislocation/unstable or coming out of socket	☐ Weakness ☐ Numbness ☐ Swelling ☐ Cracking or grinding ☐ Other:	Associated issues with: ☐ Stairs ☐ Twisting ☐ Squatting ☐ Sleeping on that side ☐ Walking ☐ Running ☐ Sitting	Trouble with: ☐ Personal Care/Self Care ☐ Domestic Work ☐ Yard and House Maintenance ☐ Work ☐ Exercise ☐ Sleep ☐ Other:

General review of Systems

Please Check **ALL** Symptoms/Issues that you get regularly or are increasing in frequency/severity:

Constitutional	☐Weight Loss ____lbs ☐Weight Gain ____lbs	☐Fever ☐Chills ☐Night Sweats	☐Appetite Loss ☐Other:
Ear, Nose & Throat	☐Blurry Vision/Blind Spots ☐Double Vision ☐Eye Pain ☐Eye Discharge	☐Color Vision Changes ☐Smell Changes ☐Taste Issues ☐Hearing Concerns ☐Tinnitus/Ear Ringing	☐Ear Pain ☐Ear Plugged ☐Other:
Neurological	☐Headaches ☐Speaking issues ☐Swallowing issues ☐Numbness ☐Balance problems ☐Tremor ☐Difficulty Rising Out of Chair ☐Fatigue with overheard work ☐Dizziness	☐Weakness ☐Dexterity Issues ☐Grip Weakness ☐Muscle Wasting ☐Spontaneous muscle movements or jerks ☐Seizures ☐Memory problems ☐Attention issues	☐Urinary Retention ☐Bowel/Stool incontinence ☐Erection Problems ☐Foot Drop with Running ☐Other:
Dermatologic	☐Skin rashes ☐Psoriasis ☐Nail Problems ☐Hair Loss ☐Dandruff	☐Muscle Cramps ☐Morning Stiffness ☐Joint Swelling	☐Raynaud's/Hand Discoloration ☐Ulcers ☐Other:
Cardiac & Respiratory	☐Chest Pain ☐Fainting/lightheaded ☐Irregular Heart Beat ☐Leg Swelling	☐Shortness of Breath ☐Cough ☐Wheeze/chest tightness	☐ Other:
Gastrointestinal & Urinary	☐Ulcers ☐Diarrhea ☐Constipation ☐Reflux ☐Blood in Stool or Urine	☐Nausea or Vomiting ☐Bloating ☐Urinary Frequency ☐Tea Colored Urine	☐Urinary Hesitancy ☐Pain with Urination ☐Other:
Endocrine	☐Heat/Cold intolerance ☐Nervousness ☐Hypoglycemia ☐Steroid Use	☐Menopause ☐Periods Irregular/Absent ☐Easy Bruising	☐Anemia ☐Bleeding ☐Other:
Sleep	☐Wake multiple times ☐Not refreshed sleep ☐Nigh time Cramps ☐Nightmares	☐Daytime somnolence ☐Snoring ☐Restless legs ☐Depressed ☐Anxious	☐Stop breathing while sleeping ☐Morning headaches ☐Other:
Add Any Other Information			

Past Medical History

Please check if you have ever been **GIVEN** a diagnosis or are being treated for:

Metabolic & Organ Based	☐Diabetes ☐Kidney Disease ☐Cholesterol ☐Urinary Symptoms ☐Interstitial Cystitis	☐Thyroid Disease ☐Liver Disease ☐Acid Reflux ☐Ulcers ☐Irritable Bowel	☐Osteoporosis ☐Other:
Cardiovascular& Respiratory	☐Angina ☐Heart Attack ☐Circulation Problems	☐Asthma ☐Emphysema ☐Blood Clots	☐Sleep Apnea ☐High Blood Pressure
Neurological	☐Stroke ☐Multiple Sclerosis ☐Migraines	☐Seizures ☐Vision Problems ☐Hearing Problems	☐Other:
Psychiatric	☐Depression ☐Post-Traumatic Stress Disorder ☐Eating Disorder	☐Anxiety ☐Bipolar Disorder ☐Personality Disorder	☐Substance Abuse or Dependence ☐Victim of Abuse ☐Other:
Rheumatologic & Musculoskeletal	☐Rheumatoid Arthritis ☐Lupus ☐Gout ☐Vasculitis	☐Fibromyalgia ☐Osteoarthritis ☐Tendinitis ☐Problem Joint: ☐Jaw Pain/Issues	☐Bursitis ☐Compartment Syndrome ☐Other:
Infections	☐Hepatitis ☐HIV/AIDS	☐Tick Bites/Lyme Disease ☐Syphilis	☐Chicken Pox ☐Tubercolosis ☐Other:
Add Any Other Information			

Surgeries/Hospitalizations

Type	Reasoning	Length of Stay	Date	Issue Require Follow-up
Surgery	*Retinal Detachment*	*<1day*	*Apr 2010*	*yes*

Medications / Allergies / Habits

Current Medications: Vitamins, Natural Products and Allergies. Please List ALL

Name	Dose	Therapeutic Effect	Side effect	How long have you been taking this med
Example: Lyrica	***75mg 2x/day***	***30%better***	***Dizziness***	***3months***

Previous Medications: Please include all Pain, Psychiatric, Natural Remedies or Sleep Medications (you can ask Pharmacy for a medication list to help with memory)

Name	Dose	Therapeutic Effect	Side Effect	How long did you take this med	Reason for stopping
Example: Lyrica	***75mg 2x/day***	***30%better***	***Dizziness***	***3months***	***Side effects***

Allergies: Include all allergies (medical and environmental)

Allergy	Response	When Discovered

Habits: Please be honest and as accurate as you can be

	Current Use	Past Use
Tabaco	☐ Cigarettes: /day ☐ Cigars: /day ☐ Pipe: /day ☐ D p	☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Dip
Alcohol	Number of drinks per week: Click here to enter text.	☐ Yes ☐ No
Caffeine	☐ Coffee: /day ☐ Energy Drinks: /day ☐ Tea (with caffeine): /day	☐ Coffee ☐ Energy Drinks ☐ Tea (with caffeine)
Street Drugs	☐ Cocaine ☐ Ecstasy ☐ Hallucinogens ☐ Heroine ☐ Marijuana ☐ Methamphetamines ☐ Opioids ☐ Other:	☐ Cocaine ☐ Ecstasy ☐ Hallucinogens ☐ Heroine ☐ Marijuana ☐ Methamphetamines ☐ Opioids ☐ Other:

For your Current Pain issues: completed or ongoing treatments

Fill out chart to the best of your memory.

Type	Ongoing?	Degree of Benefit (0-100%)	Duration of Benefit	Side Effects
Acupuncture	☐			
Active Release Therapy (ART)	☐			
Biofeedback	☐			
Chiropractic	☐			
Cold Application	☐			
Devices (cane, crutch, wheelchair, braces, etc)	☐			
Group Therapy	☐			
Heat Application	☐			
Intramuscular Stimulation (IMS)	☐			
Injection- (Give type) Click here to enter text.	☐			
Injection (Give type) Click here to enter text.	☐			
Meditation/Relaxation	☐			
Massage Therapy	☐			
Occupational Therapy	☐			
Orthoses	☐			
Osteopathy	☐			
Physiotherapy	☐			
Psychology	☐			
Shockwave Therapy	☐			
Tai Chi	☐			
TENS	☐			
Ultrasound	☐			

Yoga	☐
Other Click here to enter text.	☐
Other Click here to enter text.	☐

Social & Occupational History

Job	
Main Duties	
Current Work Schedule	
Check any that Apply	☐Changed job position more than once this year ☐New supervisor at work ☐Change in shift/work schedule ☐Change in duty requirements
Job Satisfaction	☐Very Satisfied ☐Somewhat Satisfied ☐ Not Satisfied Comments:
Are you currently on	☐Sick Leave ☐Return to Work Program ☐Restricted Duties
Do you Receive any of the Following? (check all that apply)	☐Veterans Affairs ☐Pension ☐Disability Insurance ☐CPP ☐Motor Vehicle Insurance
Pending Litigation?	☐Yes ☐No
Private Insurance?	☐Yes ☐No
Are you Married	☐Yes ☐No ☐Divorced ☐Separated ☐Common Law
How many children do you have	

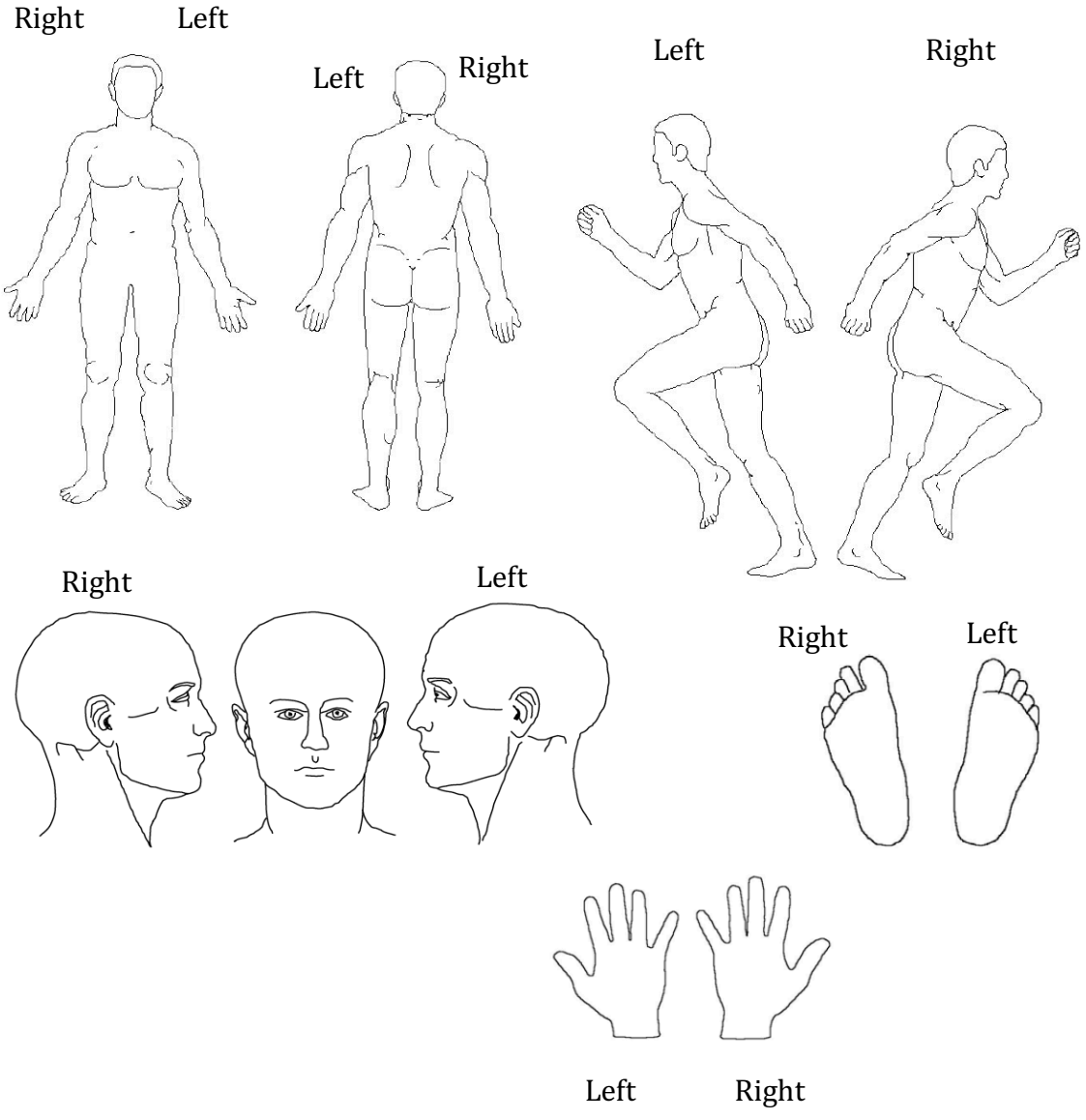
Scales

Please complete the following form by pressing on the links and filling out the surveys

Region	Outcome
Cervical Spine	Neck Pain Disability Score **(Not percentage)=**
Upper Limb: (shoulder, elbow, wrist and hand)	The Disabilities of the Arm, Shoulder and Hand (DASH) Score =
Lumbar Spine	The Oswestry Low back pain Score is:
Lower Extremity: (Hip, knee, foot and ankle)	Lower Extremity Functional Scale Result **(Not percentage)=**

PLEASE PRINT THE DOCUMENT NOW

Once printed, please indicate your areas of **PAIN** on the drawings below



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