NewWest PHYSICIANS
We put your health first

Musculoskeletal Injury Questionnaire

Patient Name:_____ Date Of Birth: _____ Date:_____

Height:_____ Weight:_____ Sex: _____ Occupation/Type Of Work:_____

Reason For Visit:_____ Did You Have An Injury? **Yes** **No**

When Did The Injury Occur?_____ Please Describe: _____

_____

Were You Referred By Another Provider? Please List: _____
Who Is Your Primary Care Doctor? _____

Any Previous Injury or Surgery to Same Area? List with Dates: _____

_____

_____

Do You Have Pain? **Yes** **No** Where Is Your Pain? _____

On a Scale of 0 – 10, Please Rate Your Pain: (0 = no pain, 10 = worst pain imaginable) _____

How Would You Describe The Pain? (Circle All That Apply) Dull Sharp Throbbing Burning

How Often Do You Have Pain? Rare Occasional Intermittent Frequent Constant

Do You Have Pain At Night? **Yes** **No**

Are You Taking Any Medications Specifically For This Problem? **Yes** **No**
Please List: _____

_____

Are You Experiencing Any Of The Following Symptoms? (Circle All That Apply)

Swelling Stiffness Redness Bruising Instability/"Giving Out" Cold Sensation of a Limb

Locking/Catching Weakness Joint Laxity/Looseness Tingling/Burning/Numbness Dislocation

Has the Condition Changed? Better Worse No Change

What Makes the Condition Better? _____

What Makes the Condition Worse? _____

Have You Seen Other Providers For This Condition? (Surgeon, Chiropractor, Acupuncturist, etc.)
Please Describe:_____

_____

Have You Had Other Treatments? (Injections, Massage, Physical Therapy, Acupuncture, etc.)
Please Describe:_____

_____

Did These Treatments Help? **Yes** **No** Please Describe: _____

_____