Musculoskeletal Injury Questionnaire

North Denver Medical and Sports Medicine Clinic

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: _____________________________________________