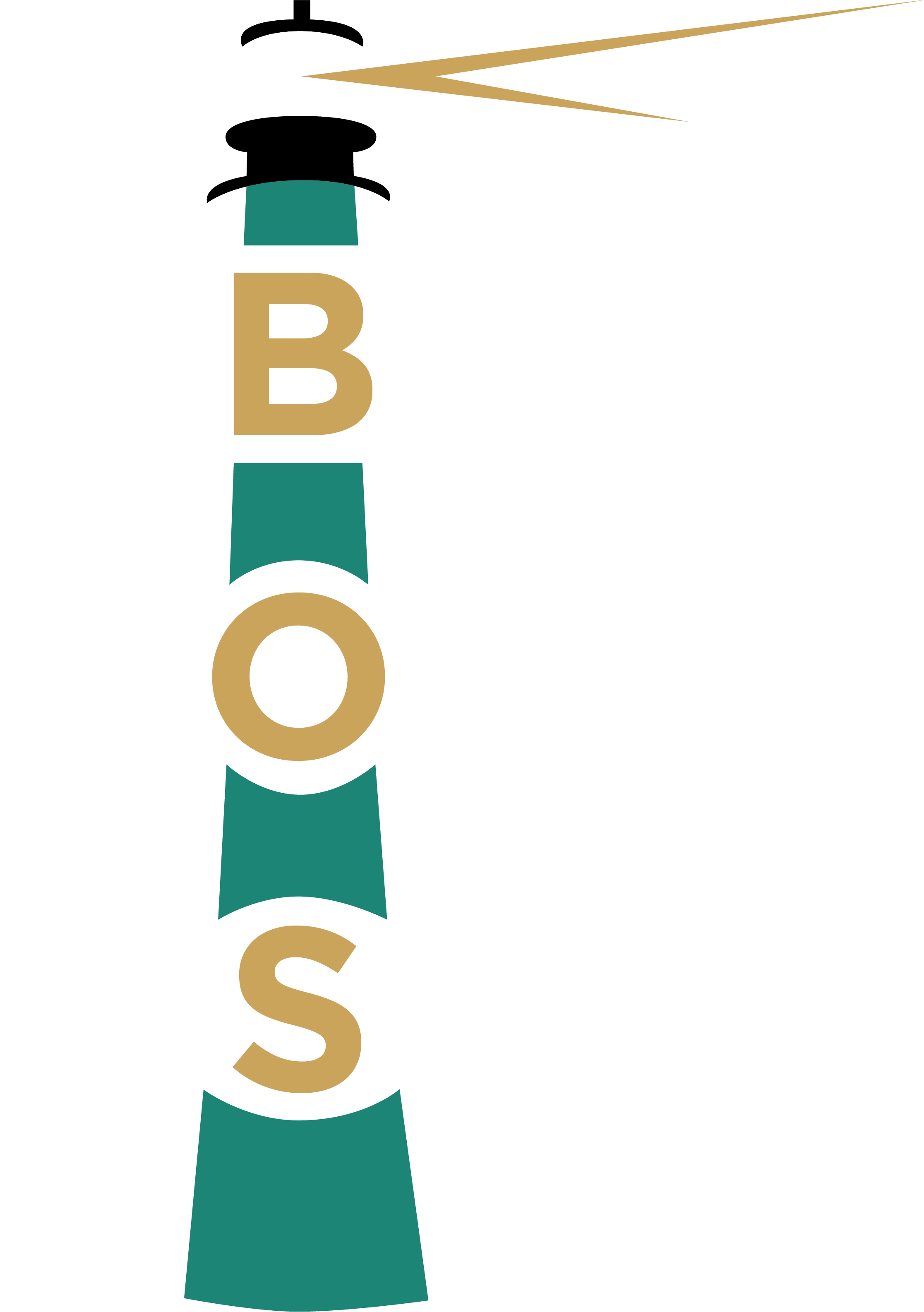
**Brevard Orthopaedic Specialists – Dr. Wade**

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**New Patient/Established New Problem Questionnaire**

\*\*Please Fill Out ALL Sections\*\*

**Body Part To Be Evaluated TODAY**: **Date of Injury, if applicable**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foot: □ Right □ Left □ Both Knee: □ Right □ Left □ Both □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ankle: □ Right □ Left □ Both Hip: □ Right □ Left □ Both

**How long have you had this pain**: \_\_\_\_\_\_\_\_\_\_Days \_\_\_\_\_\_\_\_\_Weeks \_\_\_\_\_\_\_\_\_\_ Months \_\_\_\_\_\_\_\_\_\_\_ Years

**Have you seen another provider for this same problem?** □ YES □ NO ; If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about Dr. Wade?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a previous injury to this body part in the past?** □ NO □ YES= please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had surgery to this body part in the past?** □ NO □ YES= please provide year, type of surgery, name of surgeon, city/state of surgery, if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you have any of the following**: Diabetes- □ YES □ NO / Neuropathy- □ YES □ NO / Gout □ YES □ NO

“Rheumatoid” Arthritis- □ YES □ NO / Osteoporosis(-penia)- □ YES □ NO / Tobacco Use? □ YES □ NO

Infection History of skin or wound? □ YES □ NO If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this a Worker’s Compensation Injury**: □ YES □ NO ; If yes= Where do you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you working? □ YES □ NO

**Do you have a lawyer or are you in litigation for this injury?** □ YES □ NO □ N/A

**(Females Only): Is there a possibility you may be pregnant?**  □ YES □ NO

**ADDITIONAL NOTES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Previous XR/CT/MRI?** □ NO □ YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Previous Injections?** □ NO □ YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Treatments/Physical Therapy?** □ NO □ YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*-Please circle ALL that apply in the following section-*

**Quality of Pain**: aching / burning / dull / piercing / sharp / throbbing

**Alleviating Factors**: rest / ice / heat / elevation / medication / mobility / stretching / shoes / nothing

**Aggravating Factors**: standing / walking / stair climbing / pushing off / shoes / nothing

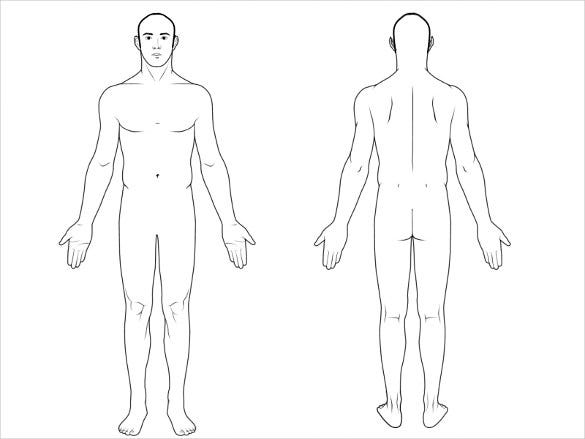
**Other Associated Symptoms:**

Bruising Decreased Mobility Instability Difficulty Going to Sleep Limping Locking

Night Pain Popping/Catching Spasms Numbness/Tingling Swelling Weakness

*-Mark the area of the body where the pain is most severe and please circle the severity on the scale-*

****10 = **worst** and 1 = **least pain 1 2 3 4 5 6 7 8 9 10**



**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

**Staff Use Below: ------------------------------------------------------------------------------**

**Exam:**

**Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Plan:** OTC Salves Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRI/CT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rx Compound

Custom Orthotic Rx Labs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescription: \_\_\_\_\_\_\_\_\_\_\_

Surgery Booking Sheet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Codes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outside Imaging: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

XR Today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brace Bootwalker Non-Covered DME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RTC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_With XR? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_