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# Dr. Deheshi's New Patient Questionnaire (4 pages)

Name: _____ Date: _____

Date of Birth: _____ Gender: Male / Female

What is the main reason for your visit today? Please specify…

Have you had a previous related injury in the past?

__ yes __ no

If you answered 'Yes', please provide details of the injury and when the injury happened…

Are you experiencing pain in any of the following areas? Select ALL that apply…

__ no pain __ right hip __ left hip __ right knee __ left knee

__ other

If selected 'Other' please specify…

Does the pain radiate to any other parts of the body? Please specify…

How would you describe the pain? Select ALL that apply…

__ no pain __ sharp __ ache __ burning __ stiffness

__ other

If selected 'Other' please specify…

How severe is your worst pain on a 0-10 scale. Zero = no pain. 10 = most severe pain experienced. Please specify…

____ / 10

Is the pain constant (non-stop) or intermittent (comes and goes)?

__ no pain __ constant __ intermittent

How long does the pain last when it occurs? (ie. Duration of the pain) Please specify…

When did the pain first start? How long ago? Please specify…

Did the pain start gradually or suddenly?

__ no pain __ gradual __ sudden

For how long has the pain been severe or intolerable? Please specify…

Do you experience any of the following additional symptoms? Select ALL that apply…

__ none __ swelling __ warmth __ redness __ numbness __ tingling

__ instability __ clicking __ popping __ locking

__stiffness after sitting __ stiffness in the morning

__ pain at rest __ night pain

__ growth or mass __ open wounds __ drainage

__ other

If you selected 'Other' additional symptoms, please specify…

Please list all factors or modalities that help improve the pain and symptoms: Select ALL that apply…

__ none __ pain medications __ ice or cooling device __ heat

__ topical ointments __ rest __ sitting __ standing __ walking

__ elevation __ exercise __ physical therapy

__ other

If you listed 'Other' alleviating factors, please specify…

What medications do you take for the pain? Please specify name, dose, and frequency (eg. Tylenol, 1 tablet every 6 hours)

Please list all factors or modalities that aggravate your pain or symptoms: Select ALL that apply…

__ none __ prolonged standing __ walking __ climbing stairs

__ sitting for prolonged period __ kneeling __ squatting __ exercise

__ changes in weather

__ other

If you listed 'Other' aggravating factors, please specify…

Do you have difficulty with any of the following activities of daily living? Select ALL that apply…

__ no difficulty __ feeding self __ getting dressed

__ putting on socks __ putting on shoes __ tying shoe laces __ cutting toe nails

__ using the toilet __ bathing __ showering

Do you have difficulty with any of the following additional activities? Select ALL that apply…

__ no difficulty __ climbing stairs __ coming down stairs

__ prolonged standing __ prolonged walking __ kneeling __ squatting

__ getting into or out of a car __ indoor housework or cleaning __ outdoor housework

__ cooking __ washing dishes

__ other

If you listed 'Other" disabilities, please specify…

How far can you walk? Please specify one of the choices… (eg. 100 yards, or 1 block etc)

__ feet __ yards __ blocks __ miles __ minutes __ hours

__ no limit

Do you use any walking aids? __ No __ Yes, If yes…

__ cane __ walker __ crutches __ wheelchair __other, please specify:

What is your current occupation if working? Please specify…

Please describe any difficulties or limitations in performing your work-related activities if working… eg. Standing for too long, lifting heavy boxes, sitting for more than 30 minutes etc.

Please describe any limitations in performing fun or recreational activities you previously enjoyed. eg. Playing soccer, going for long walks, traveling, playing with grandchildren etc.

Please list any previous treatments for the same condition. Select ALL that apply…

__ no previous treatments __ anti-inflammatory medications __ other pain medications

__ ointments __ pain patches

__ physical therapy __ occupational therapy __ chiropractic treatment

__ braces __ steroid injections __ hyaluronan or gel injections

__ plasma rich protein (PRP) injections __ stem cell injections

__ pain specialist consultations. Please specify name of pain specialist:

__ other surgical consultations. Please specify name of other surgeons:

__ prior related surgeries

Please specify ALL anti-inflammatory medications (NSAIDS) that you have tried in the past including topical (eg. Advil, Aspirin, Ibuprofen, Motrin, Aleve or Naproxen, Diclofenac gel, Voltaren gel, etc):

_____ _____ _____

_____ _____ _____

Please specify details and timing of previous treatments eg. Physical therapy 6 months ago, or steroid injection right knee in December 2018, or left knee arthroscopic surgery in 2015 etc.

Please list any additional related information that you wish to provide…