PATIENT INTAKE QUESTIONNAIRE

OPA ortho™

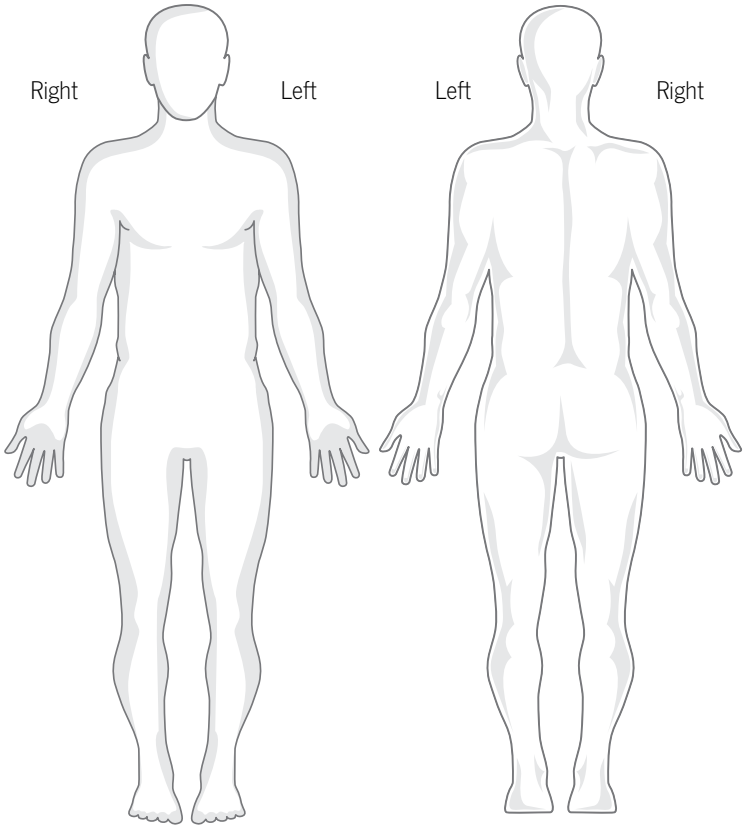
Patient Name _____ (last / first / middle initial)

DOB _____ (mm/dd/yyyy) Age _____

PAIN DRAWING

Mark these drawings using the symbols below that best describes your pain.

Pain **x** Numbness **o** Weakness **=** Ache ◊ Stabbing ****



SEVERITY OF PAIN: (at rest)

(None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

SEVERITY OF PAIN: (with activity)

(None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

Date of Onset/Injury _____

Duration of Pain _____

Location of Pain (Indicate body part where pain is present and then total pain to 100%)

Back	_____%	Buttock	_____%
Left Leg	_____%	Right Leg	_____%
Neck	_____%	Shoulder	_____%
Left Arm	_____%	Right Arm	_____%

Pain Aggravated by:

☐ Standing ☐ Sitting ☐ Walking
☐ Sleeping ☐ Driving ☐ Stairs
☐ Bending Forward ☐ Bending Backward ☐ Other_____

Pain Relieved by:

☐ Standing ☐ Sitting ☐ Walking
☐ Sleeping ☐ Driving ☐ Stairs
☐ Bending Forward ☐ Bending Backward ☐ Other_____

Treatment Attempted:

☐ Narcotics ☐ Acupuncture ☐ Injections
☐ Chiropractic ☐ Massage ☐ Surgery
☐ Physical Therapy ☐ Anti Inflammatories ☐ Other_____

Do you have numbness/weakness in your arms/legs?

☐ Yes ☐ No

Do you have any difficulties with bowel or bladder function?

☐ Yes ☐ No

How far can you walk before having to stop and rest?

_____

Do you use a cane or walker?

☐ Yes ☐ No

The above information is true and correct to the best of my knowledge.

Patient Signature _____ Date _____

M.D. Review _____ Date _____