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Motion Orthopaedics

Sports Medicine, Shoulder, Elbow and Knee Surgery

Please complete the following health questionnaire. We are concerned with your overall health, as well as your orthopedic problems. This information is confidential and will be reviewed with you by your doctor today. It is designed to help you recall your history and to provide details that will help in your diagnosis and treatment plan. Thank you.

Name: Nickname: Date:

Date of Birth: Age: Height: Weight: Sex:

Are you: Right Handed Left Handed **Are you pregnant?** Yes No

Who referred you: Relationship:

Date of Injury/ Onset: Description of job duties:

Body part to be examined:

| | | | |
|----------------------------|--------------------------------|-------------------------------|-------------------------------|
| Shoulder | Right <input type="checkbox"/> | Left <input type="checkbox"/> | Both <input type="checkbox"/> |
| Elbow | Right <input type="checkbox"/> | Left <input type="checkbox"/> | Both <input type="checkbox"/> |
| Wrist/Hand | Right <input type="checkbox"/> | Left <input type="checkbox"/> | Both <input type="checkbox"/> |
| Hip | Right <input type="checkbox"/> | Left <input type="checkbox"/> | Both <input type="checkbox"/> |
| Knee | Right <input type="checkbox"/> | Left <input type="checkbox"/> | Both <input type="checkbox"/> |
| Ankle/Foot | Right <input type="checkbox"/> | Left <input type="checkbox"/> | Both <input type="checkbox"/> |
| Other <input type="text"/> | Right <input type="checkbox"/> | Left <input type="checkbox"/> | Both <input type="checkbox"/> |

New Injury: Continued Problem: Second Opinion: Referral for Surgery:

Brief description of the injury:

Is the condition getting: Better: Worse: Same:

Rate your pain from 1 to 10 with 10 being the most painful: Now: At its worst:

Location of pain: Front Back Inside
Outside Deep Superficial
Radiating Whole Area Other:

Is the pain: Constant Dull Aching
Intermittent Sharp Stabbing
Throbbing Tingling Burning

Do you have: Weakness Stiffness Loss of Motion
Locking Catching Popping
Grinding Giving way Other:

When do you experience it most?

Anything make it better? Worse?

What treatments have you tried?

- | | | | | | |
|---------------|--------------------------|--------------|--------------------------|------------------|--------------------------|
| Rest | <input type="checkbox"/> | Ice | <input type="checkbox"/> | Compression | <input type="checkbox"/> |
| Elevation | <input type="checkbox"/> | Bracing | <input type="checkbox"/> | Physical Therapy | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | Chiropractic | <input type="checkbox"/> | Acupuncture | <input type="checkbox"/> |
| Massage | <input type="checkbox"/> | Injections | <input type="checkbox"/> | Cortisone | <input type="checkbox"/> |
| Trigger Point | <input type="checkbox"/> | Synvisc | <input type="checkbox"/> | Other: | <input type="text"/> |

Has anything helped? Yes No If yes, which?

Where were you first evaluated, for example: in an ER, an urgent care center, an occupational medicine center, or a doctor's office?

Have you been provided medications? Yes or No If yes, please list:

Have you had any x-rays, MRI's, or other tests? Yes or No If yes, please list:

Have you been recommended to have surgery? Yes or No If yes, please describe procedures and list dates:

Prior Injuries/ Traumatic Events to the same body part(s):
Have you sought medical care for the same body part? Yes or No If yes, please list:

Have you ever had a doctor/chiropractor/therapist/ or any other person in the allied medical field evaluate the same body part?
Yes or No If yes, please explain:

Are you a student, where? What grade? Sports?

Coach/Trainer's Name: Phone Number, if known:

- :
- | | | | | | | | | | |
|------------|--------------------------|------------|--------------------------|--------------|--------------------------|----------------|--------------------------|----------|--------------------------|
| Golf | <input type="checkbox"/> | Tennis | <input type="checkbox"/> | Soccer | <input type="checkbox"/> | Baseball | <input type="checkbox"/> | Football | <input type="checkbox"/> |
| Wrestling | <input type="checkbox"/> | Hockey | <input type="checkbox"/> | Running | <input type="checkbox"/> | Track/XC | <input type="checkbox"/> | Lacrosse | <input type="checkbox"/> |
| Basketball | <input type="checkbox"/> | Hunting | <input type="checkbox"/> | Skiing | <input type="checkbox"/> | Bowling | <input type="checkbox"/> | Hiking | <input type="checkbox"/> |
| Softball | <input type="checkbox"/> | Volleyball | <input type="checkbox"/> | Field Hockey | <input type="checkbox"/> | Weight Lifting | <input type="checkbox"/> | Swimming | <input type="checkbox"/> |
- Other:

I certify that this information is true and correct to the best of my knowledge. Please sign below.

Patient or Responsible Parent (if under 17 years old)

Date

By checking this box I certify & affirm my intent to sign this form electronically by typing my name above.