

# MONADNOCK ORTHOPAEDIC ASSOCIATES

YOUR NAME \_\_\_\_\_ DATE \_\_\_\_\_ PATIENT PROBLEM UPDATE FORM:

**HOW OFTEN DO YOU HAVE PAIN (Please Circle)?**

Constant with variable intensity    Constant    Daily    > 3 Days Per Week    1 To 2 Days Per Week    Occasionally

**DESCRIBE YOUR PAIN?    Other description \_\_\_\_\_**

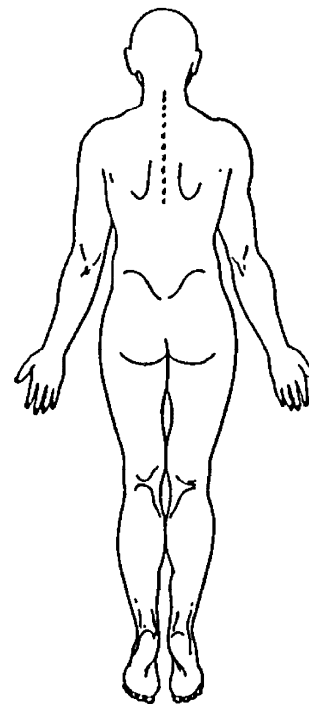
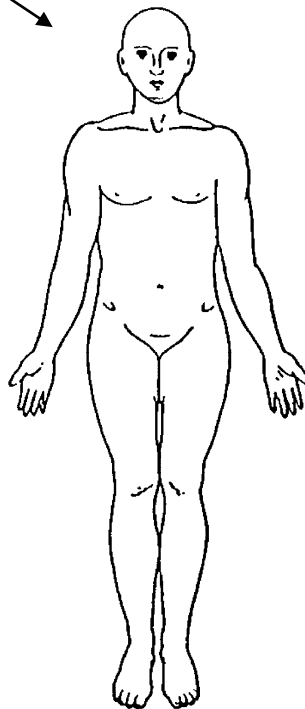
Sharp    Dull    Aching    Burning    Stabbing    Throbbing

**ARE YOU?**

Getting Worse    Improving    Staying the Same

*\* Mark the region of your problem on the model:*

**Elaborate on your Chief Complaint here:**  
When Started/ Circumstances/ Treatment Responses?



**PLEASE RATE YOUR DISCOMFORT**

(0 = No Pain and 10 = Passing out from Extreme Pain)

Right Now	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Dominant Hand

R                  L

**IF YES TO ANYTHING BELOW THEN MARK WHERE ON THE MODEL**

NUMBNESS / TINGLING/ PINS/ NEEDLES

YES    NO                  (where?)

RADIATING PAIN?

YES    NO                  (where?)

WEAKNESS?

YES    NO                  (where?)

MECHANICAL LOCKING?

YES    NO

CATCHING?

(where?)

GIVING OUT?

(where?)

WHAT **AGGRAVATES** YOUR PAIN (**CIRCLE ALL** that apply)?

Run    Sports    Twisting    Working    Driving    Climbing    Stairs    Bend Forward/Backward    Sleeping    Sitting    Standing    Walking  
Reaching Overhead    Moving Neck    Cough/sneezing    Unknown    **Other:** \_\_\_\_\_

WHAT **IMPROVES** THE PAIN?

Heat    Ice    Rest    Sitting    Lying Down    Medication    PT    Movement/Activity    Brace/ ACE wrap    Cane    Water/pool    **Other:** \_\_\_\_\_

YOUR Height \_\_\_\_\_ YOUR Weight \_\_\_\_\_ (**Office**) Pulse/ BP/BMI \_\_\_\_\_