

**Pre-Exam Questionnaire-ORTHOPEDIC  
SYNERGY Therapeutic Group**

In order to evaluate your condition fully, please be as accurate as possible, Thank you.

1. Have you ever had this pain or problem before?	Yes	No		
a. If yes, did you receive any treatments at that time?	Yes	No		
b. If yes, where?				
c. Any surgery or injections?	Yes	No		
2. List the dates and results if any.   X-rays:				
MRI's:				
3. Where is your pain or problem:	Neck	Lower back	Middle back	Other
	Elbow	Shoulder/upper arm	Hip	knee
	Foot/ankle			
a. Is it deep or on the surface?	Deep	On the surface		
b. Does it move or stay in one place?				
4. When did this problem first begin?	____ / ____ /20____ (approximate date)			
5. How did it start?				
6. My pain/problem is slowly getting:				
	worse	better	staying the same	
7. My pain bothers me				
	constantly	most of the time	only occasionally	once in a while
8. On a scale from 1 to 10, what is the worst your pain has been in the past several days				
	Mild discomfort	moderate	unbearable, severe	
1-----	5-----	10-----		
9. Do you have any regular numbness or tingling?				
	Yes	No		
10. What seems to make your pain worse?				
a. When it does get worse, how long does it take before calming back down? _____				
11. What seems to make it feel better?				

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/20\_\_\_\_  
Today' Date