ORTHOPAEDIC QUESTIONNAIRE (JCC)

Please accept our apologies for the overly lengthy and detailed for your are about to complete. Completion of this questionnaire will allow for the most complete and quickest compilation of your report.

PLEASE PRINT:

NAME_____ DATE_____

Age_____ Height_____ Weight_____

CIRCLE ONE: Right-handed Left-handed

1. Please indicate the date of the work injury for which you are being seen.

   _____

2. a. Who was your employer at the time of the injury?

   _____

   b. In what month and year did you begin work for this employer?

   _____

3. a. Briefly describe how you were injured.

   _____

   _____

   _____

   _____

   _____

   b. What body part(s) were injured?

   _____

   _____

4. How long have you been off work, or were you off work, due to this injury?

   _____

5. a. Who did you first see for medical care following the injury?

   _____

   b. What type of doctor was he or she?

_____

   c. When did you first see that doctor?

_____

6. a. What other doctors or health care practitioners have you seen in relation to your injury? _____

_____

_____

_____

b. Who is you family doctor? _____

c. Who is your current treating doctor for your work injury?_____

7. Check the type of tests you have undergone since the work injury:

Check all tests you have had:

	EEG		Myelogram		Nerve Tests(EMG/NCV)
	ENG		Spinal Tap		Urine Test
	Hearing Tests		Blood Tests		Psychological Testing
	X-rays of:		MRI of:		CT scan of:

Other tests:_____

Were you ever denied medical treatment? ( ) YES ( ) NO

If yes, explain why treatment was denied:_____

_____

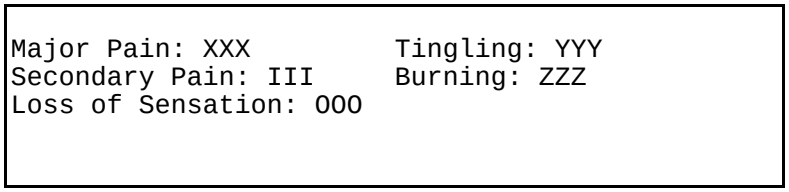
CURRENT COMPLAINTS

8. Do you have any continuing pain or discomfort currently as a result of the injury you are being evaluated for? _____

9. If yes, complete the table and diagram below:

	Affected body parts. Please list the most troublesome to the least troublesome.	Type of pain (i.e., aching, a dull deep pain; sharp: a sudden, intense knife-life pain; burning; radiating; a pain that travels.	What activities or treatment make the pain better?	What activities or treatment make the pain worse?
MOST PAINFUL				
LEAST PAINFUL				

10. Using the following key, describe your present ailment on the diagram below:



KEY

11. a. Can you drive?_____

b. Can you shop?_____

c. Can you do housework?_____

12. Are there any sports/hobbies/activities that you can no longer do because of your work injury? Are there work activities you can no longer do? ( )YES ( )NO

If YES, please explain:_____

_____

_____

The heaviest object I can lift weighs _____ pounds.

I am able to walk _____(distance).

I am able to sit for_____(minutes/hours) before I must stand.

I am able to stand for_____(minutes/hours)before I must rest.

Prior to this injury:

I could regularly lift up to _____ pounds.

I was able to walk _____ (distance).

I was able to sit for _____ (minutes/hours).

I was able to stand for _____ (minutes/hours).

PAST MEDICAL HISTORY

13. Did you have any serious **CHILDHOOD ILLNESSES**?

( )YES ( )NO If yes, what?_____

14. Did you have any **CHILDHOOD INJURIES**?

( )YES ( )NO If yes, what?_____

15. Do you have any **ADULT ILLNESSES**? (For example, high blood pressure, diabetes, lung disease, heart disease, etc.)

16. Please fill in the chart below:

List all injuries (broken bones, sprains, concussions, lacerations, etc.):

Auto Accident	Other	Year	Type of Injury	Treatment

INDUSTRIAL INJURIES:

Year	Type of Injury	Outcome

HAVE YOU EVER BEEN INVOLVED IN A LAWSUIT OR ANY TYPE OF LEGAL ACTION HAVING TO DO WITH ACCIDENTS OR HEALTH MATTERS? (YES) (NO)

If YES, please list all such occurrences:

YEAR	DESCRIPTION	OUTCOME

17. Have you had surgeries of any type? ( )YES ( )NO If YES, please indicate what type(s):

TYPE OF SURGERY MONTH/YEAR HOSPITAL DOCTOR

a. _____

b. _____

c. _____

d. _____

18. Have you had any non-surgical hospitalizations? ( ) YES ( )NO
If YES, indicate what type(s). *FEMALE PATIENTS: Please include childbirth(s).*

TYPE OF HOSPITALIZATION MONTH/YEAR HOSPITAL DOCTOR

a. _____

b. _____

c. _____

d. _____

19. Are you presently taking any medications? ( ) YES ( ) NO

If YES, please list them **ALL**:

_____

_____

_____

20. Do you have any ALLERGIES to medications? ( ) YES ( ) NO

If YES, to what?_____

21. Please indicate whether or not you use the following items and, if yes, what type and quantity:

	CURRENT USE				PAST USE	
SUBSTANCE	**YES**	**NO**	**TYPE**	**AMOUNT PER DAY**	**YES**	**NO**
Tobacco						
Alcohol						
Coffee						

FAMILY HISTORY

22. Do any illnesses run in your family? If so, please list:

_____

_____

OCCUPATIONAL HISTORY

23. What was your occupational title at the time of your work injury?

_____

24. When you were hired by the employer who you worked for at the time of your injury, was a pre-employment physical performed? ( )YES ( )NO

25. When you started this job, did you have any restrictions on your physical abilities? _____

_____

26. What were the duties of your job? Please list your job tasks. Only a brief description of each task is necessary. For example, a carpenter might...(a) build frames, (b) clean workplace, (c) carry materials, (d) etc.

a. _____

b. _____

c. _____

d. _____

27. a. Please estimate how much of the work day was spent performing the following activities:

	Not at all	Up to 1/3 of the day	Up to 2/3 of the day	More than 2/3 of the day
Sit in Chair.....	( )	( )	( )	( )
Type/Keyboard.....	( )	( )	( )	( )
Drive.....	( )	( )	( )	( )
Stand.....	( )	( )	( )	( )
Walk.....	( )	( )	( )	( )
Walk on Uneven Ground.	( )	( )	( )	( )
Climb.....	( )	( )	( )	( )
Grip.....	( )	( )	( )	( )
Reach.....	( )	( )	( )	( )
Reach Overhead.....	( )	( )	( )	( )
Twist.....	( )	( )	( )	( )
Stoop.....	( )	( )	( )	( )
Bend.....	( )	( )	( )	( )
Squat.....	( )	( )	( )	( )
Crawl.....	( )	( )	( )	( )
Push/Pull.....	( )	( )	( )	( )

Activities continued:

	Not at all	Up to 1/3 of the day	Up to 2/3 of the day	More than 2/3 of the day
Kneel.....	( )	( )	( )	( )
Lift < 10 pounds.....	( )	( )	( )	( )
Lift 10 - 25 pounds....	( )	( )	( )	( )
Lift 25 - 50 pounds....	( )	( )	( )	( )
Lift 50 - 75 pounds....	( )	( )	( )	( )
Lift 75 - 100 pounds...	( )	( )	( )	( )
Lift > 100 pounds.....	( )	( )	( )	( )

b. What was the maximum weight lifted? _____

c. How many times a day were you required to lift this weight? _____

d. What type of floor surface did you work on while at work?

( ) Cement ( ) Wood ( ) Carpet
( ) Dirt ( ) Uneven Terrain ( ) Tile
( ) Other_____

28. Do you still work for the employer? ( ) YES ( ) NO

If not, when was the last day you worked for that employer? _____

29. Did you work anywhere BEFORE this employment?

( ) YES ( ) NO (If NO, skip to Question #31)

a. Please fill in the following information regarding employment prior to the injury for which you are being seen.

1. Name of LAST prior employer_____

2. Location_____

3. Occupation/Work Duties_____

4. Period of Employment **FROM** _____ **TO**_____

b. 1. Name of LAST prior employer_____

2. Location_____

3. Occupation/Work Duties_____

4. Period of Employment **FROM** _____ **TO**_____

c. 1. Name of LAST prior employer_____

2. Location_____

3. Occupation/Work Duties_____

4. Period of Employment **FROM** _____ **TO**_____

30. Did you work for any other employer at the SAME TIME that you were

working at the job where you were injured? _____

( ) YES ( ) NO

31. If YES, then respond to the following:

a. Name of employer _____

b. Location of employer _____

c. Occupation/Work Duties _____

d. From when _____ to when _____

e. Hours per week _____

32. Have you worked anywhere **FOLLOWING** working for the employer where you were injured? ( ) YES ( ) NO

33. If YES, respond to the following:

a. Are you **CURRENTLY** employed? ( ) YES ( ) NO

b. If currently employed, by whom? _____

c. Where is the employer located? _____

d. What is your occupation there? _____

e. When did you begin work there? _____

If there are additional employers after the work injury, please fill in #34 - 36.

34. a. Name of later employer _____

b. Location of employer _____

c. Occupation/Work Duties _____

d. Period of Employment **FROM** _____ **TO** _____

35. a. Name of later employer _____

b. Location of employer _____

c. Occupation/Work Duties _____

d. Period of Employment **FROM** _____ **TO** _____

36. If you had a THIRD OR ANY ADDITIONAL later employment, please use the back of this page and answer the same questions as #34 and #35.

You're finished? Thanks again for your patience.

HQ-Clifford:5/21/09

Name:_____ Date:_____

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

_____

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Rarely — All of the time

Total pain severity score (range from 0 to 20) = _____

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to **write or type?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

/
M _____ =

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number).

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**?

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

S
/
=

Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ Your sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:

0-10	Normal range
10-12	Borderline
12-24	Abnormal