Jayakar Medical Group

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Questionnaire

Patient

Name _____

Age? _____

Height? _____ **Date** _____

Weight? _____

Are you left or right handed? L ☐ R ☐

Your Injury

Date of injury? _____

Which part of your body was injured? _____

Where were you first treated? _____

Have you seen any other specialists? _____

Have you had any diagnostic testing (x-rays, MRI or other studies)? _____

Has this injured body part had any problems prior to this? _____

If yes, please describe the problem briefly: _____

Present Time

Are you taking any medication for the injury? _____

Are you going to physical therapy? _____

Have you had surgery for the injury? _____

Are you getting better, worse or staying the same? _____

Your Work (If worker's compensation)

Company that you worked for at the time of the injury? _____

What is/was your job title? _____

How long have you been with the company? _____

Are you still employed with the company? _____

Are you still working? _____

If not, when was your last day of work? _____

Medical History

Other medical problems _____

Prior surgeries _____

Medications _____

Allergies _____

Social History

Hobbies _____

Kids _____

Marital status _____

Exercise routine _____

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