New patients need to arrive 15 minutes before their scheduled appointment time. If you are not early the appointment will be rescheduled.

Dr. Schippers Patient Name_____

New Patient Questionnaire MRN_____

1. **Hand Dominance:** RIGHT LEFT
2. Married Single Divorced Widowed
3. Who is with you at your appointment? _____
4. Who recommended you to see Dr. Schippers?_____
5. Who is your primary care provider? _____
6. **Work history**
    1. Are you currently working: YES NO
    2. If no, are you on disability or leave? _____
    3. If on disability, what medical condition causes this? _____
    4. Employer_____ Job Title _____
    5. Job Activity (please describe): _____
    6. How does your hand/ wrist problem effect job performance:
        - ☐ No restrictions ☐ Unable to work
        - ☐ Working with restrictions (describe)_____
7. **Hobbies:** please list any sports or hobbies that you enjoy to better understand how you use your hands/ arms_____
    1. Does your hand/ wrist problem affect these activities? YES NO
8. **When did your symptoms start or your injury occur?** (specify date) _____
    1. If an injury, where did it occur? _____
    2. How did the injury occur? _____
9. Is your **HAND** , **WRIST** or **ELBOW** involved (circle all that apply)?

    Which side? RIGHT LEFT BOTH
10. Have you had treatment elsewhere for this? _____
11. Previous tests (check all that apply and please list date and location if known)
    - ☐ X-rays_____ ☐ Nerve study (EMG) _____
    - ☐ CT or MRI _____ ☐ Lab tests _____
12. Previous treatment (check all that apply)

	Helpful?	
☐ Medications (specify): _____	YES	NO
☐ Occupational or Physical Therapy	YES	NO
☐ Chiropractic/ Acupuncture	YES	NO
☐ Injections (how many?): _____	YES	NO
☐ Splint/ Brace	YES	NO
☐ Surgery (what type?):_____	YES	NO

(Scan: MD Specific Form)

13. **Chief complaints** (circle all that apply):

    Pain Limited Motion Weakness Numbness Other_____

14. **Symptoms** (complete as applicable)

    PAIN ***Intensity*** (scale of 0-10)

    At its best ____ At its worst ____ At rest ____ With activity____

    Character (circle all that apply)

    Sharp & stabbing/ Dull ache/ Burning/ Throbbing/ Other_____

    Duration *(*choose one)

    Constant/ Intermittent/ With activity/ Only at night/ Other:_____

    LIMITED MOTION (please circle the cause): pain/ strength loss/ block to motion

    NUMBNESS (specify fingers/ area involved): _____

    OTHER: _____

15. What makes it worse? (circle all that apply) Pushing or pulling/ Lifting/ Grasping/ Writing

    Other: (please describe) _____

16. What makes it better? (circle all that apply) Heat/ Ice/ Massage/ Avoiding activity/ Brace Other: (please describe)_____

17. Do your pain/ symptoms affect your **sleep**? YES NO

    If yes, circle the following: prevents from getting to sleep/ awakens at night

    Frequency (please specify): every night/ ____ times a week/ ____ times a month

18. If the result of accident, is there litigation involved? YES NO

    Attorney: _____

19. Is this associated with a worker's compensation claim? YES NO

20. Other current orthopedic conditions:

Neck	No	Yes	Who is providing treatment? _____
Shoulder	No	Yes	Who is providing treatment? _____
Back	No	Yes	Who is providing treatment? _____
Hip/ Knee	No	Yes	Who is providing treatment? _____
Ankle/ Foot	No	Yes	Who is providing treatment? _____

21. Any other information that you think is important for us to know in order to optimize outcomes for your hand: _____

    _____

    _____

(Scan: MD Specific Form)