Fredericksburg Orthopaedic Associates, P.C.

Reason for Visit Questionnaire

AP# _____ Today's Date: _____

Patient's Full Name: _____Age: _____ Date of Birth:_____

Occupation: _____ Primary Care Physician:_____

Were you referred to our practice? ☐ NO ☐ YES If yes, referring physician/facility:_____

Date of Injury OR Onset of Complaint: _____

What is your chief complaint? (the reason you made your appointment) Please indicate right and left as appropriate.

_____

Describe how you were injured, or if there was no injury briefly describe the onset of your complaint.

_____

Is your chief complaint related to an auto accident? ☐ NO ☐ YES

Is this a work related injury? ☐ NO ☐ YES If yes, list worker's comp. insurance company:_____

Are you currently working? ☐ NO ☐ YES

What physician or medical facility, if any, has treated you for the above medical condition? Please include dates of treatment: _____

Have you had any previous testing? ☐ NONE ☐ X-Ray ☐ MRI ☐ CT scan ☐ Nerve Study ☐ Other: _____

What treatment(s)/medication(s) have you tried? _____

_____

Are you using any assistive devices? ☐ NONE ☐ Cane ☐ Crutches ☐ Walker ☐ Sling ☐ Brace ☐ Splint ☐ Other_____

What would you rate your pain level? (Please Circle) No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

What makes your pain worse? _____

What makes your pain better? _____

How would you describe your pain? ☐ constant ☐ intermittent ☐ dull ☐ sharp ☐ stabbing ☐ aching ☐ cramping ☐ burning ☐ night pain ☐ tingling ☐ shooting ☐ Other: _____

Have you had any of the following? ☐ limping ☐ swelling ☐ stiffness ☐ radiating pain ☐ catching ☐ locking ☐ grinding ☐ numbness ☐ instability ☐ weakness ☐ giving out ☐ warmth ☐ decreased range of motion ☐ painful range of motion

We need your help!

So we may better direct our advertising/marketing efforts, we would like to know how you came to be a new patient of Fredericksburg Orthopaedic Associates . Please help us by answering the following questions.

As a new patient, who are you here to see today?

1. ☐ Physician/Physician Assistant
2. ☐ Physical Therapy
3. ☐ Hand Therapy

Were you referred to our practice by a physician or medical facility?

1. ☐ YES……I already answered this on the first page! ☺
2. ☐ NO

If you answered "NO", how did you hear about us?

1. ☐ Family or Friend
2. ☐ I was a previous patient, but have a new injury/ailment
3. ☐ Community Newsletter
4. ☐ Newspaper article or advertisement
5. ☐ Northern Virginia Magazine annual "Top Docs" issue
6. ☐ Our Practice Web Site: **www.fredortho.com**
7. ☐ Online MD Search and/or review site (e.g. Healthgrades.com; Vitals.com)
8. ☐ Online search (Google, Yahoo, Bing, etc)
9. ☐ Community Lecture
10. ☐ FOA Lakes & Grapes Century Ride (our annual cycling event)
11. ☐ Community Healthfair
12. ☐ School or School Sponsored event
13. ☐ Yellow pages, Superpages
14. ☐ Other_____

We truly appreciate your taking the time to assist our marketing department by answering these questions.

If you have any questions about this survey or would like to make any additional comments, please email aloncar@advancemgt.com.

Thank you!