Orthopedic Questionnaire

Name: _____Date: _____

Please evaluate your feelings about your health on each of the following categories. Check (use a check mark) the number that corresponds to your self-assessment, where the range is from **10=excellent to 1=very poor**. **Pain**: Use **Ø** for no pain and a **+** for yes there is pain.

	10	9	8	7	6	5	4	3	2	1	NA	Pain
Overall Muscular Strength												
Overall Joint conditions												
Osteoarthritis (Arthritis)												
Fibromyalgia												
Rheumatoid Arthritis												
Lupus Arthritis												
Psoriatic Arthritis												
Cervical Spine												
Right Shoulder												
Left Shoulder												
Thoracic Spine												
Right Elbow												
Left Elbow												
Right Wrist and hand												
Left Wrist and hand												
Thoracic Spine												
Scoliosis												
Kyphosis												
Herniated Discs												
Lumbar Spine												
Scoliosis												
Herniated Discs												
Prior Surgical results												
Hips												
Knees												
Right Knee												
Left Knee												
Right Ankle												
Left Ankle												
Right Foot												
Left Foot												

JUDITH A INGALLS MD

Helping patients through the mid-life transition in Arizona and Colorado

Orthopedic Questionnaire

Prior Fracture(s) or Orthopedic Surgery

Bone/Limb	When	Why	Comment

Physician's Notes: