

Symptom Questionnaire
Dr. Alvin J. Detterline
Towson Orthopaedic Associates

Patient Name: _____

Date of Birth: _____

Reason for Visit

Left

Right

Hip

Thigh

Leg

Ankle

Foot

Shoulder/Collarbone

Arm

Elbow

Forearm

Wrist

Hand

Duration of Symptoms

____ Days

____ Weeks

____ Months

____ Years

Onset of Symptoms

No injury

Date of Injury _____

Gradual Process – Getting Better

Gradual Process – Getting Worse

Description of Pain (Check all that apply)

Dull Ache

Burning

Throbbing

Shooting

Sharp

Constant

Stabbing

None

Symptoms Occur with (Check all that apply)

Sitting

Reaching

Standing

Lifting

Walking

Sleeping

Running

With Movement

At Rest