Joint Pain and Function Questionnaire
Orthopedic Associates of Flower Mound and Denton

Instructions

Check the boxes next to the choices that best describe your symptoms and treatment to date. All questions must be answered. **Please check all that apply. More than one choice per question is allowed.** If uncertain of exact time frames, please estimate to the best of your ability.

Please note that Medicare and many private insurance companies are now requiring more extensive documentation of the patient's symptoms, condition, and treatment prior to the consideration of total joint replacement. They require specific and extensive non-operative treatment trials prior to approving surgery for total joint replacement.

The following symptoms and conditions must be documented for consideration of total joint replacement:

- Pain at the joint involved
- Pain increased with activity
- Pain increased with weight bearing
- Pain that interferes with activities of daily living
- Pain with passive range of motion
- Limited range of joint motion
- Joint grinding or noise (if knee)
- Joint swelling (if knee)
- Limping gait (if hip)
- X-ray findings consistent with degenerative joint disease

Specifically, the pre-surgery treatment trials include:

- Continued pain symptoms after trial of medication greater than 4 weeks
- Trial of physical therapy (unless patient unable to tolerate) greater than 12 weeks
- Trial of external joint support (cane, walker, brace) greater than 12 weeks

The Physicians of Orthopedic Associates will strive to relieve your pain and improve your function with the least invasive treatment required. Often, arthritic pain can be controlled or mitigated with a variety of non-operative treatments. Unfortunately, many non-operative treatments for arthritis often have diminishing returns and eventually cease to be effective. At that time, total joint replacement can become the treatment of choice, offering a proven durable solution in resolving arthritic pain and improving function.

Please be thoughtful and detailed in your completion of these forms. They will aid in determining the best treatment of your knee or hip problem. Thank you for your assistance.

The Physicians of Orthopedic Associates

Name: _____ DOB: _____ Date: _____

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Part I: Pain and Motion

1. Where is your pain located?
   - ☐ Hip
   - ☐ Knee
   - ☐ Both
   - ☐ Low back with radiation down leg

2. Which side(s) is/are involved?
   - ☐ Left
   - ☐ Right
   - ☐ Both
     - If both, is one side worse than the other?
       - ☐ Left
       - ☐ Right
       - ☐ Equal

3. How long have you had symptoms of pain?
   - ☐ Less than 3 months
   - ☐ 3 - 12 months
   - ☐ 1 - 2 years
   - ☐ > 2 years
   - ☐ List length of time: _____

4. On a scale of 1-10 (1 being minimal and 10 being severe), what is your level of pain?
   - Overall? _____
   - With activity? _____
   - At rest? _____

5. Has your pain worsened recently?
   - ☐ Yes
   - ☐ No

6. Do you have pain at rest?
   - ☐ Yes
   - ☐ No

7. Do you have pain at night?
   - ☐ Yes
   - ☐ No

8. Do you notice diminished motion and stiffness of your joint(s)?
   - ☐ Yes
   - ☐ No

9. Do you have joint swelling?
   - ☐ Yes
   - ☐ No

10. Do you notice noise (clicking, creaking) when you move your joint(s)?
   - ☐ Yes
   - ☐ No

11. Do you experience weakness in the involved extremity?
   - ☐ Yes
   - ☐ No

12. Do you limp due to pain or weakness?
   - ☐ Yes
   - ☐ No

13. Have you fallen or stumbled recently due to pain or weakness?
   - ☐ Yes
   - ☐ No

14. Do you feel that your leg gives way causing you to be unstable in your walking ability/gait?
   - ☐ Yes
   - ☐ No

15. Do you require assistance to get up from a chair?
   - ☐ Yes
   - ☐ No

16. Do you require assistance to ambulate (cane, walker, companion)?
   - ☐ Yes
   - ☐ No

17. Is your overall function declining due to your joint pain?
   - ☐ Yes
   - ☐ No

18. How far can you walk before experiencing **any** pain?
   - ☐ Less than 10 feet (exam room chair to the door)
   - ☐ 11-30 feet (exam room chair to x-ray department)
   - ☐ 31-100 feet (exam room chair to waiting room)
   - ☐ more than 100 feet (exam room chair to parking lot)

19. What worsens your pain?
   - ☐ Motion of the involved joint
   - ☐ Going from a sitting to standing position
   - ☐ Weight bearing (standing/walking)
   - ☐ Everyday activities (getting dressed, using the bathroom, climbing stairs)
   - ☐ All the above

Name: _____ DOB: _____ Date: _____

20. What **significantly** decreases your pain?
    - ☐ Nothing
    - ☐ Rest
    - Oral medication
        - ☐ Anti-inflammatories (e.g. ibuprofen, Naprosyn, Celebrex, Mobic)
        - ☐ Acetaminophen (Tylenol)
        - ☐ Narcotic pain reliever
    - Injections
        - ☐ Corticosteroids into the affected joint
        - ☐ Hyaluronic acid (gel or rooster comb injections)
    - ☐ Physical therapy or exercises
    - ☐ Weight loss
    - ☐ Nutritional supplements (glucosamine/chondroitin sulfate)

21. Does anything **completely** relieve your pain?
    - ☐ Yes
        - If yes, list treatment: _____
        - How long does complete relief last? _____
    - ☐ No

22. Can you tolerate physical therapy exercises?
    - ☐ Yes, I am currently in physical therapy
    - ☐ No, I have tried and could not tolerate physical therapy due to pain
    - ☐ No, I am too limited by pain
    - ☐ No, I am too weak
    - ☐ No, I am unstable in my ability to walk
    - ☐ Other: _____

23. Can you tolerate/use anti-inflammatories (e.g. ibuprofen, Naprosyn, Celebrex, Mobic)?
    - ☐ Yes
    - ☐ No, give reason:
        - ☐ Allergic reaction
        - ☐ Renal disease
        - ☐ Interference with blood pressure medication
        - ☐ Anticoagulant (blood thinner – Coumadin, Plavix, Xarleto) use
        - ☐ GI condition (peptic ulcer disease or gastroesophageal reflux disease)

Name: _____ **Part 2: Treatment** Date: _____

Treatment	Duration (how long?)	Pain relief response (none/mild/moderate)	Lasting pain relief (yes/no)	Complications or adverse reations
e.g. Motrin	*6 weeks*	□ *none* □ *mild* □ *moderate*	*yes* *no*	*ulcer*
Medications	> 4 weeks minimum			
☐ **Anti-inflammatory** **Name: _____**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
☐ **Tylenol**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
☐**Narcotic** **Name:_____**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
Exercises	> 12 weeks minimum			
☐ **Physical therapy**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
☐ **Home exercises**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
External joint support	> 12 weeks minimum			
☐ **Cane**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
☐ **Crutches**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
☐ **Walker**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
☐ **Brace**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
Joint injections				
☐ **Corticosteroid** **# of injections: _____** **last received: _____**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	
☐ **Hyaluronic acid (gel)** **# of series: _____** **last received: _____**		☐ none ☐ mild ☐ moderate	☐ yes ☐ no	