

### Medical Profile Questionnaire

Please fill out the following questionnaire as completely as possible. This enables your Physical Therapist to establish a clinical profile upon which a safe and appropriate therapy program is planned.  
Your input is very important

Where is your pain? Using the following symbols, please mark on the drawing the areas where you feel pain:

**Symbols:**

- Pain (circle area)
- Numbness // // // // //
- Pins/Needles :: :: :: :: ::
- Shooting pain ↓

What does the pain feel like? (sharp, aching, burning, etc.)

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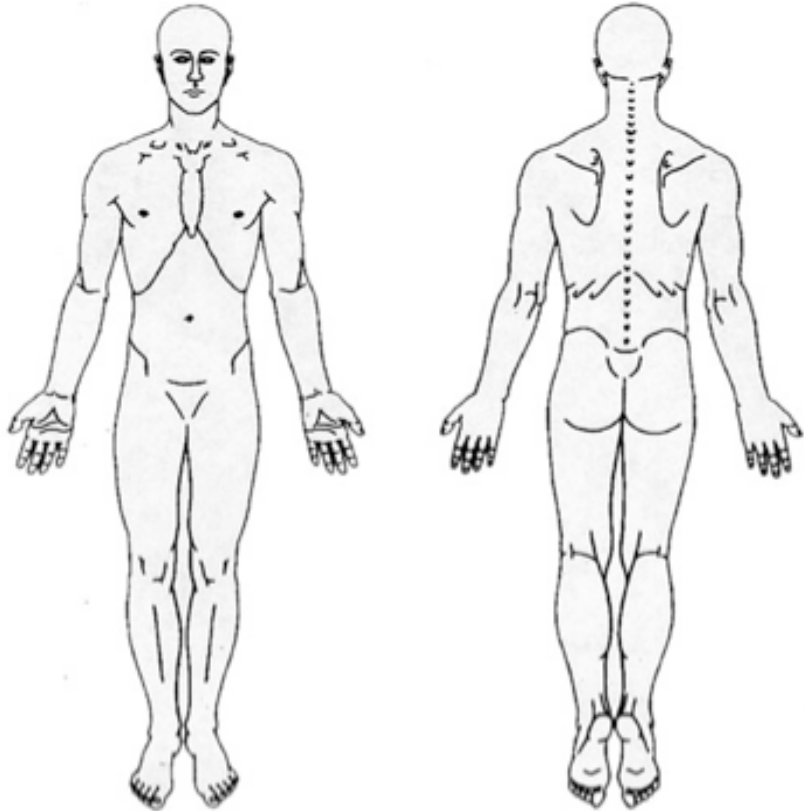
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Date of onset: 

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If this was an injury, check the appropriate boxes. Briefly describe how it happened.

- Motor vehicle
- Work injury
- Sports
- Other

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On a scale of zero to ten, with zero (0) being “NO PAIN: or “PAIN FREE” and ten (10) as the “WORST PAIN” you can imagine, **rate:**

The best it has been \_\_\_\_ The worst it has been \_\_\_\_ Your pain today \_\_\_\_

What makes your pain symptoms BETTER?

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Have you had this problem before?      \_\_ YES                      \_\_ NO

**IMPORTANT: PLEASE COMPLETE OTHER SIDE →**

**Referring Physician:**

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**Date of last doctor's visit/exam:**

**Date of next visit/exam:**

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**Family Physician/Internist:**

**Month/year last visit:**

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**Check if you take any of the following MEDICATIONS:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Steroids (cortisone)       | <input type="checkbox"/> Anti-inflammatory                   | <input type="checkbox"/> Pain killers       |
| <input type="checkbox"/> Muscle relaxants           | <input type="checkbox"/> Anti-coagulants<br>(blood thinners) | <input type="checkbox"/> Insulin (diabetes) |
| <input type="checkbox"/> Blood pressure medications | <input type="checkbox"/> Heart medication                    | <input type="checkbox"/> Other _____        |

**I have a history of (check any that apply):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer/tumors                 | <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Poor Circulation                     |
| <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Epilepsy/seizures                 | <input type="checkbox"/> Bruising easily                      |
| <input type="checkbox"/> Shortness of breath           | <input type="checkbox"/> Blackouts                         | <input type="checkbox"/> Asthma                               |
| <input type="checkbox"/> Heart trouble/angina          | <input type="checkbox"/> Frequent falls                    | <input type="checkbox"/> Hearing problems                     |
| <input type="checkbox"/> Coronary artery disease       | <input type="checkbox"/> Severe pain at night              | <input type="checkbox"/> Thyroid problems                     |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Night sweats                      | <input type="checkbox"/> Bladder problems                     |
| <input type="checkbox"/> Pacemaker/Nitroglycerin patch | <input type="checkbox"/> Smoking                           | <input type="checkbox"/> Chest/abdominal or<br>pelvic surgery |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Recent & sudden weight<br>changes | <input type="checkbox"/> Headaches                            |

For WOMEN (check if yes):

- I have had a recent pelvic exam (PAP)
- I am or may be PREGNANT
- I have had a recent mammogram or breast exam

For MEN (check if yes):

- I have had a recent prostate exam

**Allergies:** Medications, food other (i.e. tape, beeswax, etc). List reactions (such as hives, rash, shock, tongue swelling, breathing difficulty, etc.)

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**Surgery:**

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**Imaging:** X-Rays, MRI, CT (specify by name and dates of studies & results if known):

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Patient signature:

Date:

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