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

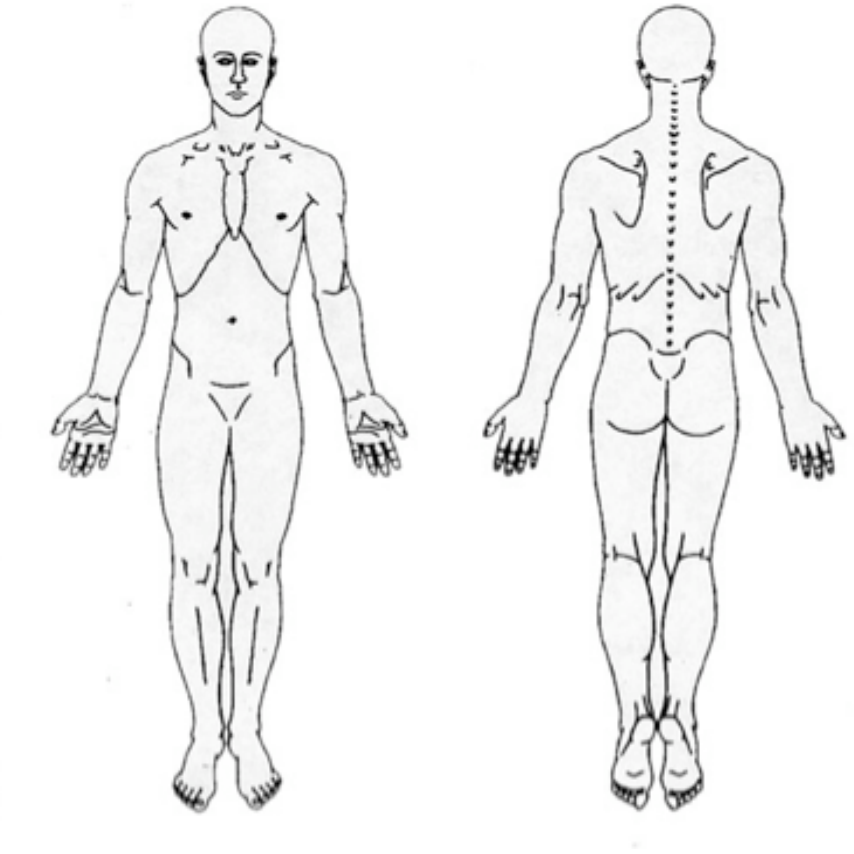
Where is your pain? Using the following symbols, please mark on the drawing the areas where you feel pain:

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

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

_____
_____
_____
_____
_____
_____

Date of onset: _____



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

❑ Motor vehicle ❑ Work injury ❑ Sports ❑ Other

_____

_____

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?

_____

_____

Have you had this problem before? __ YES __ NO

IMPORTANT: PLEASE COMPLETE OTHER SIDE →

Referring Physician:

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

Family Physician/Internist: **Month/year last visit**:

Check if you take any of the following MEDICATIONS:

- ❑ Steroids (cortisone)
- ❑ Anti-inflammatory
- ❑ Pain killers
- ❑ Muscle relaxants
- ❑ Anti-coagulants (blood thinners)
- ❑ Insulin (diabetes)
- ❑ Blood pressure medications
- ❑ Heart medication
- ❑ Other _____

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

- ❑ Cancer/tumors
- ❑ Dizziness
- ❑ Poor Circulation
- ❑ Osteoporosis
- ❑ Epilepsy/seizures
- ❑ Bruising easily
- ❑ Shortness of breath
- ❑ Blackouts
- ❑ Asthma
- ❑ Heart trouble/angina
- ❑ Frequent falls
- ❑ Hearing problems
- ❑ Coronary artery disease
- ❑ Severe pain at night
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Night sweats
- ❑ Bladder problems
- ❑ Pacemaker/Nitroglycerin patch
- ❑ Smoking
- ❑ Chest/abdominal or pelvic surgery
- ❑ Arthritis
- ❑ Recent & sudden weight changes
- ❑ 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.)

Surgery:

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

Patient signature: Date: