MEDICAL PROFILE QUESTIONNAIRE

Name: _____ Age: _____ Dominant Hand: _____

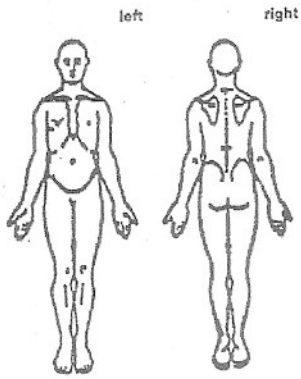
Occupation: _____

PRESENT SYMPTOMS – Please describe your complaints:

LOCATION/RADIATION:

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 ↓



CHRONOLOGY/TIMING/ONSET

How long have symptoms been present?

Is this the first episode? _____Yes _____No
If no, when have you had similar symptoms?

What was the mechanism of injury?

QUALITY

Pain type: _____Sharp _____Aching _____Burning _____Throbbing
_____Superficial _____Deep _____Radiating _____Tingly _____Numb

Pattern since onset:	_____Better	_____Worse	_____Same	_____Fluctuating
Pain/symptoms present in:	_____Morning	_____Mid-day	_____Evening	_____Night
Pain/symptoms worst in:	_____Morning	_____Mid-day	_____Evening	_____Night
Pain/symptoms least in:	_____Morning	_____Mid-day	_____Evening	_____Night

Does it keep you awake? _____
Does it wake you up? _____
Describe your sleeping position: _____.

SEVERITY

Intensity: 0 = no pain worst pain = 10

0 1 2 3 4 5 6 7 8 9 10

Frequency: _____Constant _____Intermittent
If constant, does the intensity vary???

FACTORS THAT INFLUENCE YOUR SYMPTOMS
What activities/positions increase your symptoms (sit, lay, stand, rest, activity, walk, etc)?

What activities/positions decrease your symptoms?

Have you had any treatment for this episode?

Have you had any diagnostic testing – i.e. x-ray, MRI, CT scan, etc.???

Are you taking any medications? Please list them :

ACTIVIITES OF DAILY LIVING:

Circle activities that are difficult for you and then check the appropriate box.

Activity	No difficulty	With difficulty/pain	Cannot perform
Person Hygiene: Hair, bathing, toilet.			
Dressing: Zippers/buttons, upper body, lower body, shoes.			
Household chores: Reach overhead, lifting/carrying, dusting, vacuuming, mopping. **Meal preparation:** Use stove, do dishes.			
Yard/Garden: Mowing, tilling, weeding, raking, watering.			
Walking: Stairs, curbs, incline, decline, uneven ground, distances. **Transportation:** Drive self, ride with others, bus, taxi, shopping.			

LIST YOUR LEISURE ACTIVITIES (circle those affected by your current problem): _____

_____

GENERAL MEDICAL

Have you or anyone in your immediate **family** EVER been diagnosed as having any of the following conditions?

	YOU	FAMILY	if family, WHO
A: Cancer	YES	YES	_____
If yes, describe what kind:	_____		
B: Heart problems:	YES	YES	_____
C: High blood pressure:	YES	YES	_____
D: Asthma:	YES	YES	_____
E: Emphysema:	YES	YES	_____
F: Chemical dependency (i.e. alcoholism)	YES	YES	_____
G: Thyroid problems:	YES	YES	_____
H: Diabetes:	YES	YES	_____
I: Multiple Sclerosis:	YES	YES	_____
J: Rheumatoid arthritis:	YES	YES	_____
K: Other arthritic problems:	YES	YES	_____
L: Depression:	YES	YES	_____
M: Hepatitis:	YES	YES	_____
N: Tuberculosis:	YES	YES	_____
O: Stroke:	YES	YES	_____
P: Kidney disease:	YES	YES	_____
Q: Anemia:	YES	YES	_____
R: Epilepsy:	YES	YES	_____
S: Insomnia:	YES	YES	_____
T: Constipation/diarrhea:	YES	YES	_____
U: Osteoporosis:	YES	YES	_____

V: Other: _____

Who are you currently seeing for this and any other conditions?

A: Family Practice
B: Internist
C: Orthopedist
D: Neurologist
E: Cardiologist
F: Pediatrics
G: Podiatrist
H: Chiropractor
I: Osteopath
J: OB/Gynecologist
K: Other list type: _____

Who is your PCP (Primary Care Physician)?

Have you had previous physical therapy for this problem? YES NO

Did it help? YES NO