Line physical therapy

MEDICAL PROFILE QUESTIONNAIRE

Please fill out the following questionnaire as completely as possible

Name: ____ Age: _______

Please describe your current symptoms:

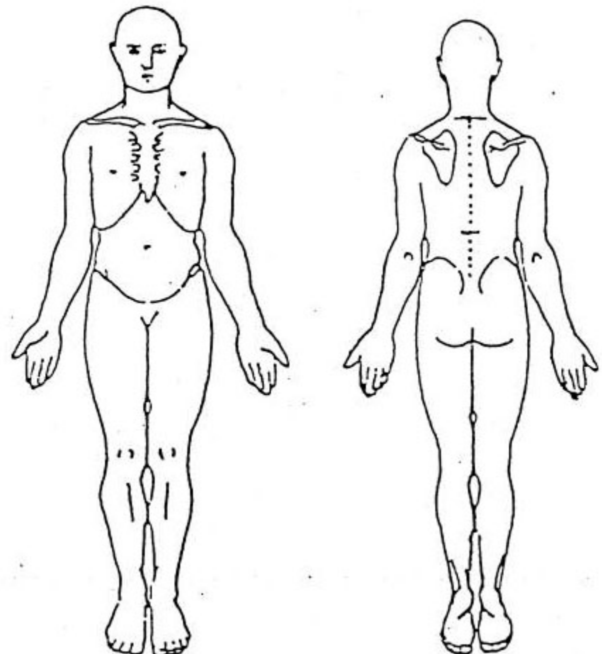
How long have the symptoms been present? _________________ Date of onset: _____________

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

□ No injury/accident □ Motor vehicle accident □ Work Injury □ Sports □ Other

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

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



If you have more than one area of pain,
Which area start first? ___________
Was there an injury for the second area? _____

Progression of injury: □ Better □ Same □ Worse □ Fluctuating

Frequency Of Symptoms: □ Constant □ Intermittent

Pain/Symptoms Type:

□ Sharp □ Aching □ Throbbing
□ Tingling □ Deep □ Radiating
□ Dizzyness □ Numb □ Burning
□ Other ____________

Rate your pain on a scale of 0-10 from best (0) to worst (10):

The worst it has been ______ The best it has been ______ Today's pain _______

Pain/Symptoms present in: □ Morning □ Mid-day □ Evening □ Night
Pain/Symptoms WORSE in: □ Morning □ Mid-day □ Evening □ Night
Pain/Symptoms LEAST in: □ Morning □ Mid-day □ Evening □ Night
Does it keep you awake? □ Yes □ No
Does it wake you up? □ Yes □ No

Do your symptoms keep you from sleeping in your normal position? □ Yes □ No
What activities increase your symptoms?

What decreases your symptoms?

Have you had any physical therapy for your current problem? □ Yes □ No
Did it help? □ Yes □ No

What type of leisure or recreational activities are affected by your current problem?

Have you had any testing done (X-Ray, MRI, CT scan, etc)? □ Yes □ No

MEDICAL HISTORY
I have a history of: (please check all that apply)

□ Cancer/tumors	□ Dizziness	□ Poor circulation	□ Osteoporosis
□ Asthma	□ Poor circulation	□ Blackouts	□ Epilepsy/siezures
□ Hearing problems	□ Heart problems	□ Shortness of breath	□ Blackouts
□ Heart trouble	□ Severe night pain	□ Bladder problems	□ Diabetes
□ Night sweats	□ Smoking	□ Arthritis	□ Latex allergy
□ Headaches	□ Recent and sudden weight changes		□ Currently pregnant
□ Stroke	□ Other: ____________		

List your recent surgeries:

Are you currently taking any of the following medications?

□ Steriods (cortisone)	□ Anti-inflammatory	□ Pain killers
□ Muscle relaxants	□ Anti-coagulants (blood thinners)	□ Insulin (diabetes)
□ Blood pressure meds	□ Heart medications	□ Other _______________

Please list any allergies:

Do you have a history of falls? □ Yes □ No
If yes, how many falls have you had in the past year? ______ Were you injured? ______

Who are you currently seeing for this or any other condition? (Primary Care Physician, Orthopedist, Neurologist, Chiropractor, etc.)

Who is your referring Physician? _______________________________
When is your next appointment with your referring Physcian? ________________________________
Who is your PCP (Primary Care Physician)? __________________________________

OCCUPATION: ____________________________
Are you currently working? □ Yes □ No
If yes, are you working □ Reduced hours □ Normal hours □ Extra hours

What are your goals for Physical Therapy?