



MEDICAL PROFILE QUESTIONNAIRE

Please fill out the following questionnaire as completely as possible. This enables your therapist to design a safe and appropriate treatment plan for you. Your input is very important.

Last Name: _____ First Name: _____ Middle Initial: _____

How did you hear about us? Physician Friend/Family Internet Phone Book Other: _____

Age: _____ Height: _____ Weight: _____ Referring Physician: _____ Date of Last Visit: ____ / ____ / ____

Occupation: _____ Current Status: Full Time Part Time Retired

Diagnosis: _____ Normal Duty Light Duty

CASE HISTORY: Date of Onset: _____ Onset due to: _____

Briefly describe how it happened: _____

Recent symptom trend: Improving Unchanged Worsening

Surgery: Yes No Date of Surgery: ____ / ____ / ____ Surgery performed: _____

Diagnostic Testing: (Check all that apply) None X-ray MRI Bone Scan CT Scan EMG
 NCV Other: _____ Results if Known: _____

CURRENT COMPLAINTS: Difficulty Walking Imbalance Loss Function Numbness Tingling
 Pain Stiffness/Tightness Weakness Other: _____

PAIN:

Pain Frequency: Constant Steady Constant Variable Comes & Goes
 Occasional (less than daily) Sporadic (less than weekly)

Pain Quality: (Check all that apply) Aching Burning Dull Pulsing Stabbing Steady Throbbing

Pain Rating:

Rate your pain on a scale from 0 – 10.
(0 = NO PAIN AND 10 = WORST PAIN you can imagine.)

Your pain today..... _____.

The best it has been since the injury..... _____.

The worst it has been since the injury... _____.

Pain Behavior:

Does time of the day affect your symptoms? Yes No

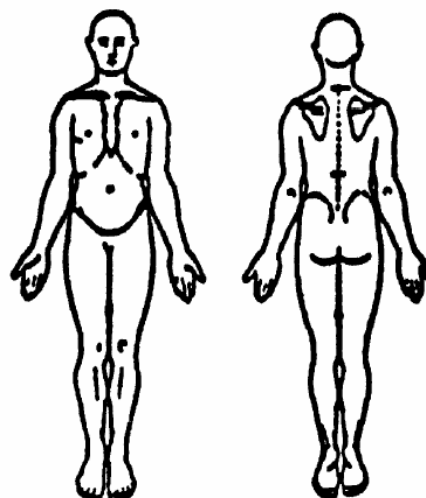
Do you have any numbness or tingling? Yes No

Where: _____

What activities make you better? _____

What activities make you worse? _____

Pain Localization: Draw the painful areas on the body diagram



Functional level at present: (List the activities that you are currently unable to do because of your diagnosis/pain)
