MEDICAL PROFILE QUESTIONNAIRE

Name: ___________________________ Age: _______ Occupation: ____________

PRESENT SYMPTOMS:
Please describe your complaints: _____________________________________________

LOCATION/RADIATION:
Where is your pain? _______________________________________________________

Using the suggested symbols to the right, please mark the area where you feel pain.

Pain: circle area
Numbness:  l  l  l  l
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? ________________________________

How did you get hurt? _________________________________________________

QUALITY

Pain Type   Sharp   Aching   Burning   Throbbing
Superficial   Deep   Radiating   Tingling   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?  Yes   No
Does it wake you up?  Yes   No

Describe your sleeping position: ___________________________________________

FACTORS THAT INFLUENCE YOUR SYMPTOMS:
What activities/positions make you feel worse? (sit, lie down, stand, rest, activity, walk, etc.)

What activities/positions make you feel better?

Have you had any treatment for this episode?

Have you had any diagnostic testing, i.e. X-Ray, MRI, CT scan, etc.?  Yes  No
If yes, please list: _______________________________________________________

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

- A: Family Practice
- B: Internist
- C: Orthopedist
- D: Neurologist
- E: Cardiologist
- F: Pediatrician
- G: Podiatrist
- H: Chiropractor
- I: Osteopath
- J: O/B Gynecologist
- K: Massage Therapist
- L: Acupuncturist

Have you had previous physical therapy for this problem?  Yes  No

LIST YOUR LEISURE ACTIVITIES  (Circle those affected by your current problem.)

GENERAL MEDICAL

Have you, or anyone in your immediate family, EVER been diagnosed with any of the following conditions?

<table>
<thead>
<tr>
<th></th>
<th>You</th>
<th>Family</th>
<th>If family, WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Cancer</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>B</td>
<td>Heart problems</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>High blood pressure</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Asthma</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>E</td>
<td>Emphysema</td>
<td>Yes</td>
<td>Yes</td>
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<td>F</td>
<td>Chemical dependency: (i.e. alcoholism)</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>G</td>
<td>Thyroid problems</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>H</td>
<td>Diabetes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>I</td>
<td>Multiple Sclerosis</td>
<td>Yes</td>
<td>Yes</td>
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<td>J</td>
<td>Rheumatoid arthritis</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>K</td>
<td>Other arthritic problems</td>
<td>Yes</td>
<td>Yes</td>
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<td>L</td>
<td>Depression</td>
<td>Yes</td>
<td>Yes</td>
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<td>M</td>
<td>Hepatitis</td>
<td>Yes</td>
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<td>N</td>
<td>Tuberculosis</td>
<td>Yes</td>
<td>Yes</td>
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<td>O</td>
<td>Stroke</td>
<td>Yes</td>
<td>Yes</td>
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<td>P</td>
<td>Kidney disease</td>
<td>Yes</td>
<td>Yes</td>
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<td>Q</td>
<td>Anemia</td>
<td>Yes</td>
<td>Yes</td>
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<td>R</td>
<td>Epilepsy</td>
<td>Yes</td>
<td>Yes</td>
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<td>S</td>
<td>Insomnia</td>
<td>Yes</td>
<td>Yes</td>
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<td>T</td>
<td>Constipation/Diarrhea</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>U</td>
<td>Mental Health/Psychiatric</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

List any surgeries
List any allergies
List medications you are currently taking