MEDICAL PROFILE QUESTIONNAIRE

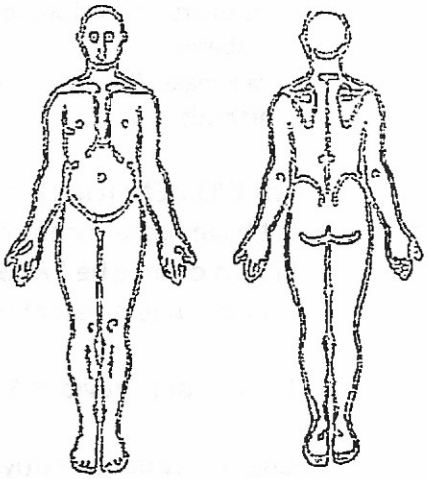
Please fill out the following questionnaire as completely as possible. This enables your Physical Therapist to establish a clinical profile upon which a safe and appropriate therapy program is planned. Your input is very important.

NAME:_____ AGE:_____ Dominant Hand: ☐ Right ☐ Left

PRESENT SYMPTOMS: Please describe your complaints:

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 2 or more areas of pain:
What area started first? _____
Was there an injury for the second area?
☐ Yes ☐ No

Pattern since onset: ☐ Better ☐ Worse
☐ Same ☐ Fluctuating

Pain Type:

☐ Sharp	☐ Tingling	☐ Deep	☐ Burning	☐ Dizziness
☐ Throbbing	☐ Aching	☐ Numb	☐ Radiating	☐ Other

Rate your pain from best to worst: 0-10

The worst it has been____ The best it has been ____ Your pain today____
What activities increase your symptoms (sit, lay, stand, rest, activity, walk, etc)?

What decreases your symptoms (sit, lay, stand, rest, activity, walk, etc)?

Have you had previous physical therapy for this current problem: ☐ Yes ☐ No
Did it help relieve your symptoms? ☐ Yes ☐ No

Please list any other treatment you have had for this current problem (massage, chiropractic, physical therapy, etc).

Have you had previous episodes with similar symptoms? ☐ Yes ☐ No
If yes, when? _____

MEDICAL PROFILE QUESTIONNAIRE (PAGE 2/2)

List your LEISURE ACTIVITIES affected by your current problem.

TEST RESULTS: (Imaging, X-Ray, MRI, CT specify by name and dates of studies and results if known):

MEDICAL HISTORY

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	☐ Headaches	☐ Recent and sudden weight changes

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

List all your previous SURGERIES:

Check if your currently 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_____

ALLERGIES: (i.e. medications, food, tape, beeswax, etc). List reactions such as hives, rash, shock, tongue swelling, breathing difficulty, etc.

HISTORY OF FALLS (unintentional change in positon causing an individual to land at a lower level, on an object, the floor or ground)

How many falls have you had in the last year? ☐ None ☐ One fall ☐ 2 or more falls

If you fell, did any of the falls result in injury? ☐ Yes ☐ No

What are your goals for Physical Therapy?

_____

_____