Medical Profile Questionnaire

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

Last name:_____________________ **First name:**______________________ **Middle initial:**____

Age:_______ **Height:**________ **Weight:**________

Occupation:__________________________________ **Currently working?** ☐ **Yes** ☐ **No**

Referring Physician:_______________________ **Date of last visit:**_______________________

Family Physician:_________________________ **Date of last physical:**____________________

1. What problem or diagnosis brings you to this physical therapy office?

____

2. When did symptoms begin? ____

3. If this was an injury, circle the appropriate description:

☐ **Motor vehicle accident** ☐ **Work injury** ☐ **Sports** ☐ **Unknown** ☐ **Other**

Date of Injury (if applicable): ____________________

4. Briefly describe your symptoms:____

____

5. How did your symptoms start: ____

____

6. How often do you experience your symptoms:

☐ Constantly (76%-100% of the time)

☐ Frequently (51%-75% of time)

☐ Occasionally (26%-50%of time)

☐ Intermittently (0%-25% of time)

7. How much have your symptoms interfered with your usual daily activities? (including both work inside and outside the home)

☐ not at all ☐a little bit ☐moderately ☐quite a bit ☐extremely

8. Average pain intensity: (please circle)

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

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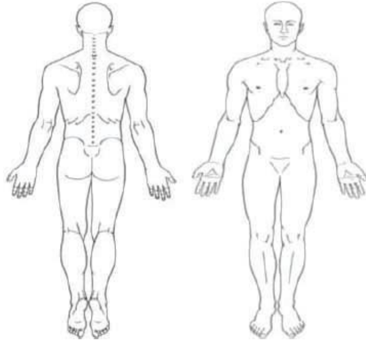
9. Indicate where you have pain or other symptoms:



10. Do you have any numbness and/ or tingling?

☐ YES ☐ NO If yes, describe where:__________________________ _____

11. Is your pain affecting your ability to sleep through the night?

☐ YES ☐ NO

12. Is your pain affected by the time of day? ☐ YES ☐ NO

13. Does coughing or sneezing increase your symptoms? ☐ YES ☐ NO

14. What makes your pain or symptoms BETTER? ____

15. What makes your pain or symptoms WORSE? ____

16. The following tests have been completed:

☐ X-ray ☐ MRI ☐ CAT ☐ EMG ☐ Other: (_______________) ☐ None

17. Have you had this problem before? ☐ YES ☐ NO If YES, describe the past history and what treatment was helpful: ____

____

18. Before the present problem, what exercises were you doing and how frequently? _____________

____

19. What do you hope to gain from therapy? ____

____

20. In general, would you say your overall health right now is:

☐excellent ☐very good ☐good ☐fair ☐poor

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21. Check if you are recently taken any of the following MEDICATIONS:

- ☐ **Steroids (cortisone)**
- ☐ **Anti-inflammatory**
- ☐ **Pain Killers**
- ☐ **Heart medication**
- ☐ **Blood pressure medication**
- ☐ **Anti-coagulants (blood thinners)**
- ☐ **Muscle relaxants**
- ☐ **Insulin (diabetes)**
- ☐ **Other:** ____

22. I have a history of (check all that apply):

- ☐ **Cancer (tumors)**
- ☐ **Epilepsy/seizures**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Night sweats**
- ☐ **Dizziness**
- ☐ **Bruising easily**
- ☐ **Heart trouble/angina**
- ☐ **Severe pain at night**
- ☐ **Osteoporosis**
- ☐ **Coronary artery disease**
- ☐ **Poor circulation**
- ☐ **Shortness of breath**
- ☐ **Frequent falls**
- ☐ **Blackouts**
- ☐ **Bowel/bladder problems**
- ☐ **Pacemaker/nitroglycerine patch**
- ☐ **Chest, abdominal, or pelvic surgery**
- ☐ **Major surgery to neck, spine, or back**
- ☐ **Smoking/tobacco use**
- ☐ **Other:** ____

Comments: ____

FEMALES:

I have had a pelvic exam within the last 12 months: ☐ **YES** ☐ **NO**

I have had a mammogram or breast exam within the last 12 months: ☐ **YES** ☐ **NO**

I am or may be PREGNANT: ☐ **YES** ☐ **NO**

MALES:

I have had a prostate exam within the last 12 months: ☐ **YES** ☐ **NO**

Signature: ____ *Date:* ___________________