GREENLAKE
Sports Physical Therapy

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Medical Profile Questionnaire

Patient Name: _____ Date: _____

Describe your symptoms _____

_____

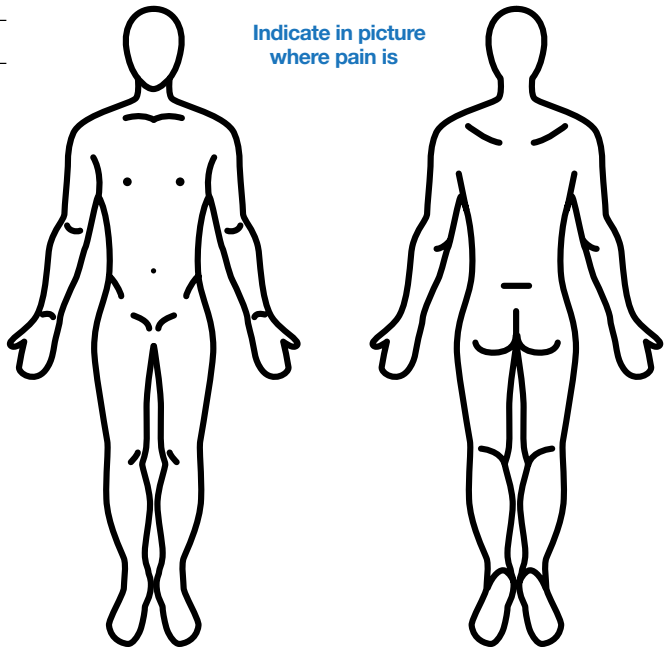
_____

_____

a. When did your symptoms start? _____

b. How did your symptoms start? _____

Indicate in picture where pain is



How often do you experience your symptoms?

☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently 0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Shooting
☐ Dull ache ☐ Burning
☐ Numbness / Tingling

How are your symptoms changing?

☐ Getting better
☐ Not changing
☐ Getting worse

During the past 4 weeks:

a. Indicate the average intensity of your pain • *circle one*

None Moderate Unbearable

1 2 3 4 5 6 7 8 9 10

b. How much has pain interfered with your normal work (including both work outside the home and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past 4 weeks how much of the time has your condition interfered with social activities?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

In general would you give say your overall health right now is…

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Who have you seen for your symptoms?

☐ No one ☐ Medical doctor ☐ Chiropractor ☐ Physical Therapist Other: _____

Have you had similar symptoms in the past? ☐ Yes ☐ No

What is your occupation?

☐ Professional / Executive ☐ Laborer ☐ Tradesperson ☐ White collar/Secretaria l ☐ Homemaker
☐ Student ☐ Retired Other: _____

If you are not retired, or a homemaker what is your current work status?

☐ Full time ☐ Part time ☐ Unemployed ☐ Off work ☐ Self Employed Other: _____

Patient Signature verifying statements are true: _____

Referring Physician: _____

Date of last doctor's visit/exam:_____ Date of next visit/exam: _____

Family Physician/Internist: _____ Month/year last visit:_____

Check if you currently take any of the following MEDICATIONS:

☐ Steroids (cortisone)	☐ Anti-inflammatory	☐ Pain killers
☐ Muscle relaxants	☐ Anti-coagulants (blood thinners)	☐ Insulin (diabetes)
☐ Blood pressure meds	☐ Heart medication	Other:_____

I have a history of: *(check any that apply)*

☐ Cancer / tumors	☐ Dizziness	☐ Diabetes
☐ Heart trouble/Angina	☐ Hearing Problem	☐ Bruise easily
☐ Coronary Artery Disease	☐ Osteoporosis	☐ Arthritis
☐ Pacemaker/nitroglycerin patch	☐ Stroke	☐ Asthma
☐ Poor circulation	☐ Bladder problem	☐ Headaches
☐ High Blood Pressure	☐ Epilepsy/seizures	☐ Blackouts
☐ Recent & sudden weight changes	☐ Shortness of breath	☐ Smoking
☐ Chest, abdominal or pelvic surgery	☐ Frequent Falls	☐ Night sweats

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

Have you had a concussion in the last 6 months? Yes or No *(circle one)* If yes, are you cleared for activity? Yes or No *(circle one)*

Name of healthcare professional who cleared you for activity:_____

Allergies: *(medications, food, tape, latex, beeswax, others)*
Please list reactions such as hives, rash, shock, difficulty breathing etc.: _____

_____

Surgery:_____

_____

Imaging, X-rays, MRI, CT: *(specify by name & date of studies & results if known)* _____

_____

_____
Signature of patient or guardian over 18 Date

_____
Print name if signed on behalf of the patient Relationship Date