

Medical Profile Questionnaire

Patient Name: _____ Date: _____

Describe your symptoms _____

a. When did your symptoms start? _____

b. How did your symptoms start? _____

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

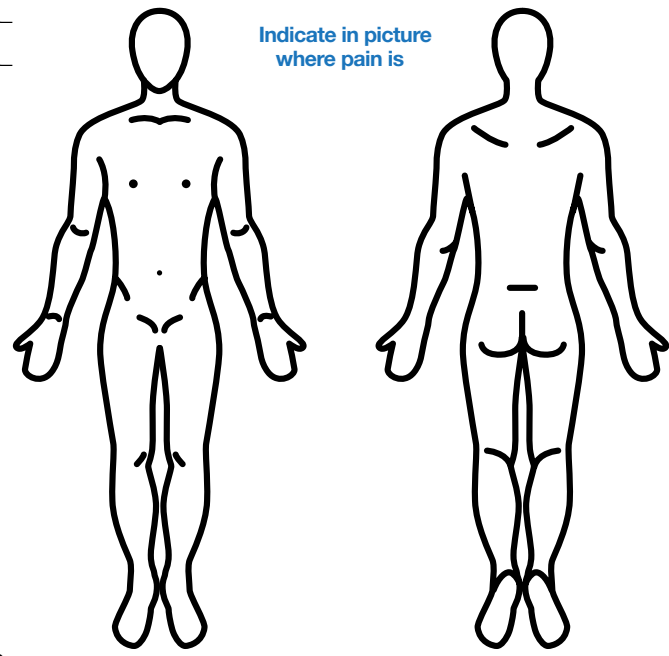
What is your occupation?

- Professional / Executive
- Laborer
- Tradesperson
- White collar/Secretaria I
- 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 16 _____ Date _____

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