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

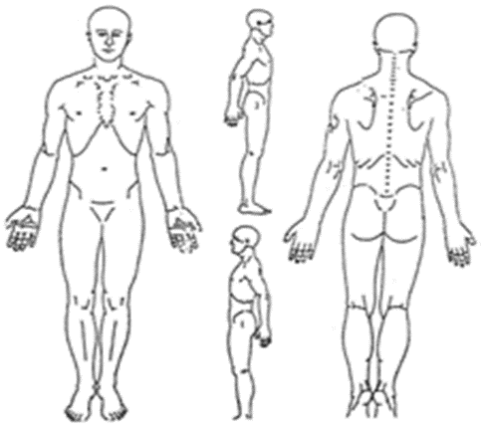
Medical Profile Questionnaire					
Full Name			**Date**		
Height			**Weight**		
Occupation Information	**Company**		**Currently Working**	**Yes**	**No**
	Work Restrictions	**No Modified Full Duty Light Duty**	**Date Last Worked**		
Chief Complaint					
Onset Date					
Type of Injury Circle any that may apply	**New Injury**	**Re-Injury**	**No Specific Injury/Gradual Onset**	**Sports Injury**	
	Auto	**Fall**	**Worker's Compensation**		
Specific Injury If Applicable					
Surgery Information	**Date**				
	Type				

Previous Tests or Treatments for this issue (Circle all that apply and comment)		
MRI	Results:	
X-Ray	Results:	
EMG	Results:	
Injections	Area injected:	Response:
P.T.	Where/Who?	Response:
Chiropractic	Where/Who?	Response:

****Pain Intensity** (Name location of pain and rate intensity from 0 "no pain" to 10 "take me to the ER now"				
Location 1		**Current _____/10**	**Best _____/10**	**Worst _____/10**
Location 2		**Current _____/10**	**Best _____/10**	**Worst _____/10**

Functional Status: Name activities that are difficult for you to do because of this condition. Rate how difficult the activity is currently.				
	Unable to do	Mild Limitation	Moderately Limited	Severely Limited
	Unable to do	Mild Limitation	Moderately Limited	Severely Limited
	Unable to do	Mild Limitation	Moderately Limited	Severely Limited

Color in the areas of pain on the diagram.
Mark areas of numbness or tingling with x's.



****Medical History**
List prior Surgeries with dates:
List any medical conditions:
**List medications with dosage or provide a list to be scanned into your chart: