Please fill out this questionnaire completely. Any areas left blank will require additional time before actual treatment can begin.

Medical Profile Questionnaire			
Full Name		**Date**	
Family Doctor			
Referring Doctor			

Occupation Information	**Occupation**		**Currently Working**	**Yes or No**
	Work Restrictions	**None** **Modified** **Light Duty**	**Date Last Worked**	
What brings you in today?				
When did your symptoms begin?				

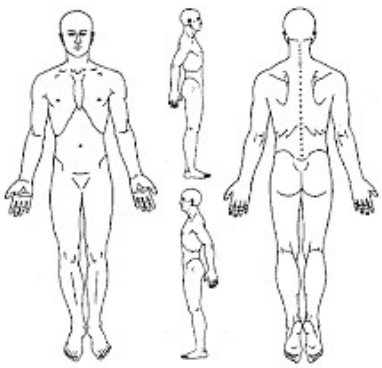
Type of Injury Circle any that may apply	**New Injury** **Re-Injury** **No Specific Injury/Gradual Onset** **Sports Injury** **Auto** **Fall** **Worker's Compensation**
If this is surgery related, fill in the following	**Date**
	Type

**** 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**

Name activities that are difficult for you to do because of the is condition/ Rate how difficult the activity is currently. Possible examples: Sitting, Standing, Walking, Bending, Sleeping, Working, Reaching overhead or behind back			
	Unable to do	Mild Limitation	Severely Limited
	Unable to do	Mild Limitation	Severely Limited
	Unable to do	Mild Limitation	Severely Limited

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:

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: