Medical Profile Questionnaire					
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?					
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**

Medical History

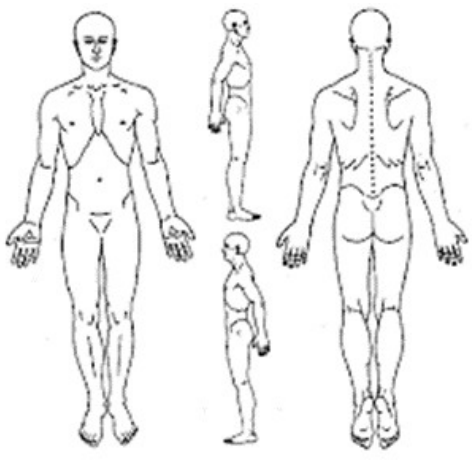
List prior surgeries with dates:

List any medical conditions:

Medicine Name	Dosage	Frequency	Route of administration
			Oral/Topical/Inhalation/Injection/or Other:
			Oral/Topical/Inhalation/Injection/or Other:
			Oral/Topical/Inhalation/Injection/or Other:
			Oral/Topical/Inhalation/Injection/or Other:
			Oral/Topical/Inhalation/Injection/or Other:
			Oral/Topical/Inhalation/Injection/or Other:
			Oral/Topical/Inhalation/Injection/or Other:

If additional space is needed please use the back of the paper.

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



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