CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Cascade Medical Rehabilitation Services
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MEDICAL PROFILE QUESTIONNAIRE

Name: _____ Age: _____ Occupation: _____

PRESENT SYMPTOMS: **Email:** _____

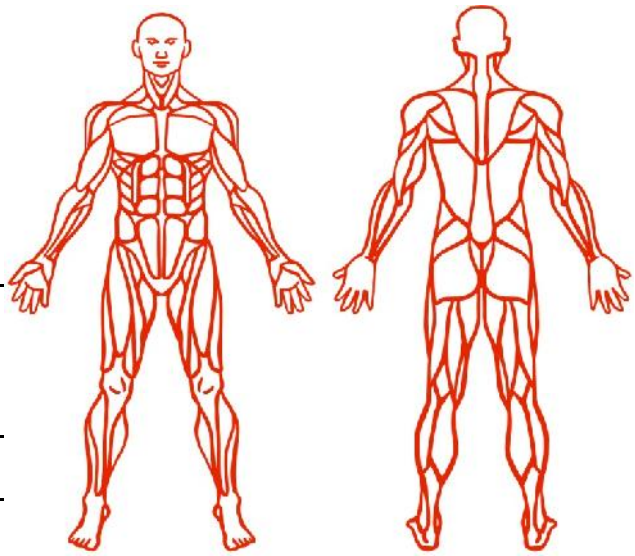
Please describe your complaints: _____

LOCATION/RADIATION:

Where is your pain? _____

Using the suggested symbols to the right, please mark the area where you feel pain.

Pain: circle area
Numbness: / / / /
Pins/Needles: ……
Shooting Pain:



CHRONOLOGY/TIMING ONSET:

How long have symptoms been present? _____

Is this the first episode? Yes No
If no, when have you had similar symptoms?
_____

How did you get hurt? _____

QUALITY

Pain Type _____ Sharp _____ Aching _____ Burning _____ Throbbing
_____ Superficial _____ Deep _____ Radiating _____ Tingling _____ Numb

Pattern since onset: _____ Better _____ Worse _____ Same _____ Fluctuating

Pain/symptoms present in: _____ Morning _____ Mid-Day _____ Evening _____ Night
Pain/symptoms worst in: _____ Morning _____ Mid-Day _____ Evening _____ Night
Pain/symptoms least in: _____ Morning _____ Mid-Day _____ Evening _____ Night

Does it keep you awake? Yes No
Does it wake you up? Yes No
Describe your sleeping position: _____

FACTORS THAT INFLUENCE YOUR SYMPTOMS:

What activities/positions make you feel worse? (sit, lie down, stand, rest, activity, walk, etc.)
_____

What activities/positions make you feel better? _____

Have you had any treatment for this episode? _____

Have you had any diagnostic testing, i.e. X-Ray, MRI, CT scan, etc.? Yes No
If yes, please list: _____

(OVER)

Who are you currently seeing for this and any other conditions?

A:	Family Practice	E:	Cardiologist	I:	Osteopath
B:	Internist	F:	Pediatrician	J:	O/B Gynecologist
C:	Orthopedist	G:	Podiatrist	K:	Massage Therapist
D:	Neurologist	H:	Chiropractor	L:	Acupuncturist

Have you had previous physical therapy for this problem? Yes No

LIST YOUR LEISURE ACTIVITIES (Circle those affected by your current problem.) _____

_____

GENERAL MEDICAL

Have you, or anyone in your **immediate** family, EVER been diagnosed with any of the following conditions?

		You	Family	If family, WHO
A:	Cancer			
	If yes, describe what kind _____	Yes	Yes	_____
B:	Heart problems	Yes	Yes	_____
C:	High blood pressure	Yes	Yes	_____
D:	Asthma	Yes	Yes	_____
E:	Emphysema	Yes	Yes	_____
F:	Chemical dependency: (i.g. alcoholism)	Yes	Yes	_____
G:	Thyroid problems	Yes	Yes	_____
H:	Diabetes	Yes	Yes	_____
I:	Multiple Sclerosis	Yes	Yes	_____
J:	Rheumatoid arthritis	Yes	Yes	_____
K:	Other arthritic problems	Yes	Yes	_____
L:	Depression	Yes	Yes	_____
M:	Hepatitis	Yes	Yes	_____
N:	Tuberculosis	Yes	Yes	_____
O:	Stroke	Yes	Yes	_____
P:	Kidney disease	Yes	Yes	_____
Q;	Anemia	Yes	Yes	_____
R:	Epilepsy	Yes	Yes	_____
S:	Insomnia	Yes	Yes	_____
T:	Constipation/Diarrhea	Yes	Yes	_____
U:	Mental Health/Psychiatric	Yes	Yes	_____

List any surgeries _____

List any allergies _____

List medications you are currently taking _____