

MEDICAL/FUNCTIONAL QUESTIONNAIRE

Date: _____

Patient Name: _____

Clinic Number: _____

Have you EVER been diagnosed as having any of the following conditions:

YES NO Cancer (Kind: _____)	YES NO Diabetes	YES NO Stroke
YES NO Epilepsy/Seizures	YES NO Asthma	YES NO Anemia
YES NO Heart Problems/Pacemaker	YES NO Arthritis	YES NO Osteoporosis
YES NO Circulation Problems	YES NO Pregnancy	YES NO High/Low Blood Pressure
YES NO Hepatitis	YES NO Emphysema/Bronchitis	
YES NO Tuberculosis	Other: _____	

Please describe any significant injuries, diseases or conditions for which you have required medical attention (include fractures, dislocations, sprains, surgeries, joint replacements) and the approximate date:

Do you have any allergies (including medications)?

Current Medications (including over-the-counter medications):

Describe your injury or problem (including date of onset):

Diagnostic Tests (X-ray, MRI, CT Scan, etc.):

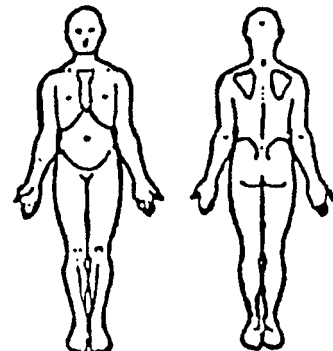
When are you going to see your physician next?

Rate your current pain on a scale of 0 to 10, where 0 is no pain and 10 is the worst pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

Mark on the diagram where you feel your pain:

Chief complaint/Describe your pain:



OF THE ACTIVITIES LISTED BELOW, CIRCLE THE ONES YOU WOULD NORMALLY DO, BUT ARE NOW HAVING PROBLEMS WITH BECAUSE OF YOUR CURRENT CONDITION. THEN CIRCLE THE AMOUNT OF DIFFICULTY THAT YOU ARE HAVING. THANK YOU!

ACTIVITIES

AMOUNT OF DIFFICULTY

	Mild	Moderate	Severe
1. Getting in and out of a chair	1	2	3
2. Getting in and out of bed	1	2	3
3. Taking a shower or bath	1	2	3
4. Hair care/Shaving	1	2	3
5. Brushing your teeth	1	2	3
6. Sleeping through the night	1	2	3
7. Getting in and out of a car	1	2	3
8. Driving	1	2	3
9. Preparing a meal	1	2	3
10. Prolonged Sitting	1	2	3
11. Carrying/Lifting a child/bag of groceries	1	2	3
12. Walking in the house or outside	1	2	3
13. Doing light housework (i.e. dusting, mopping, vacuuming)	1	2	3
14. Making the bed	1	2	3
15. Putting on a shirt or undergarment	1	2	3
16. Putting on a pair of pants, sock or shoes	1	2	3
17. Walking up and down a curb	1	2	3
18. Walking up and down a flight of stairs	1	2	3
19. Recreation/Hobbies/Sports Describe: _____	1	2	3
20. Prolonged Standing	1	2	3
21. Kneeling/Squatting	1	2	3
22. Carrying a backpack	1	2	3
23. Swallowing	1	2	3
24. Computer work	1	2	3
25. Endurance (i.e. doing an activity for an extended period)	1	2	3
26. Looking up	1	2	3
27. Turning your head	1	2	3
28. Reaching overhead	1	2	3