



MotionCare
Movement for a better life.

Medical History

Your Name: (first middle last) _____ Date: _____

What condition brings you here? _____

Is your pain or injury?

NEW PREVIOUS WORK RELATED MOTOR VEHICLE ACCIDENT SPORTS INJURY

Check any pertinent items: Associated medications / conditions:

Pregnant _____

Cancer _____

Heart Problems _____

Circulatory problems _____

Respiratory problems _____

Stomach / Bowel problems _____

Urinary problems _____

High blood pressure _____

Diabetes _____

Infectious diseases _____

Pacemaker _____

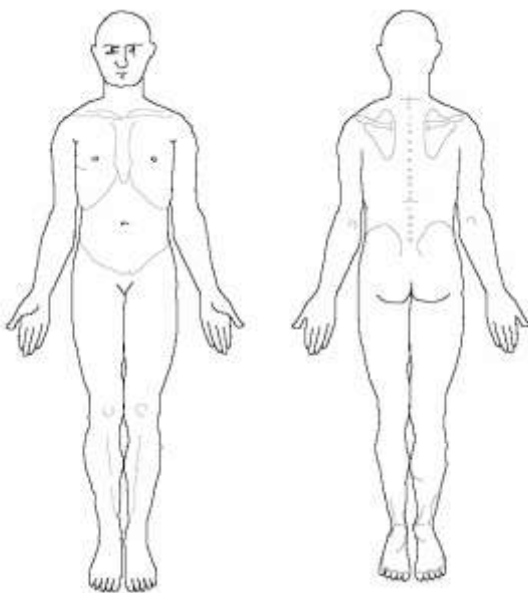
Implants _____

Allergies _____

Stroke _____

Epilepsy / Seizures _____

Other medical conditions _____



Please mark the location of your irritation and where it travels.
0 indicates no irritation - 10 indicates intolerable irritation

1. How bad is your pain/irritation?
0----1----2----3----4----5----6----7----8----9----10

2. How frequent is your pain/irritation?
0----1----2----3----4----5----6----7----8----9----10

3. How bad is your numbness/tingling?
0----1----2----3----4----5----6----7----8----9----10

4. How frequent is your numbness/tingling?
0----1----2----3----4----5----6----7----8----9----10

Functional Condition

List Any: Lost work time _____

Activity / Work restrictions _____

Indicate how you are doing by CHECKING the number that best describes your ability TODAY

- | | Completely able to do
0 | | Half ability
5 | | Completely unable to do
10 | | | | | | | | | | | | | | | | |
|--|-----------------------------------|-------|--------------------------|-------|--------------------------------------|-------|---|-------|---|-------|---|-------|---|-------|---|-------|---|-------|---|-------|----|
| 1. Rate Your Ability to Sit | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 2. Rate Your Ability to Stand: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 3. Rate Your Ability to Walk: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 4. Rate Your Ability to Bend Forwards: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 5. Rate Your Ability to Lift and Carry: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 6. Rate Your Ability to Participate in Your Normal Sport or Recreational Activities: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 7. Rate Your Ability to Work: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 8. Rate Your Ability to have Sexual Relations: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 9. Rate Your Ability to Sleep: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |
| 10. Rate Your Overall Ability to Perform Your Normal Daily Activities: | 0 | ----- | 1 | ----- | 2 | ----- | 3 | ----- | 4 | ----- | 5 | ----- | 6 | ----- | 7 | ----- | 8 | ----- | 9 | ----- | 10 |

Who referred you to MotionCare?

Medical Doctor Insurance provider Physical Therapist Chiropractor Family Friend
High School / College Co-worker Other _____

Patient Signature: _____ Date: _____