



# Medical History

Your Name: (first middle last) \_\_\_\_\_ Date: \_\_\_\_\_

What condition brings you here? \_\_\_\_\_

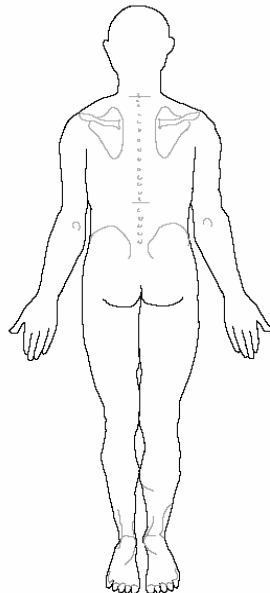
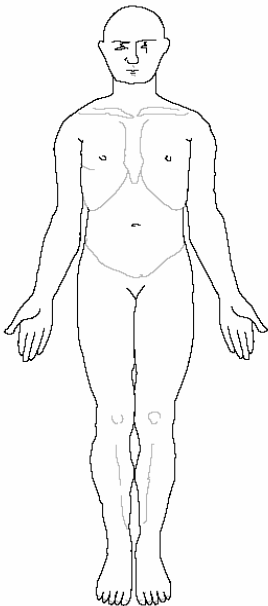
Is your pain or injury?

- NEW    
  PREVIOUS    
  WORK RELATED    
  MOTOR VEHICLE ACCIDENT    
  SPORTS INJURY

Check any pertinent items:

Associated medications / conditions:

- |   |       |
|---|-------|
| <input type="checkbox"/> Pregnant                 | _____ |
| <input type="checkbox"/> Cancer                   | _____ |
| <input type="checkbox"/> Heart Problems           | _____ |
| <input type="checkbox"/> Circulatory problems     | _____ |
| <input type="checkbox"/> Respiratory problems     | _____ |
| <input type="checkbox"/> Stomach / Bowel problems | _____ |
| <input type="checkbox"/> Urinary problems         | _____ |
| <input type="checkbox"/> High blood pressure      | _____ |
| <input type="checkbox"/> Diabetes                 | _____ |
| <input type="checkbox"/> Infectious diseases      | _____ |
| <input type="checkbox"/> Pacemaker                | _____ |
| <input type="checkbox"/> Implants                 | _____ |
| <input type="checkbox"/> Allergies                | _____ |
| <input type="checkbox"/> Stroke                   | _____ |
| <input type="checkbox"/> Epilepsy / Seizures      | _____ |
| <input type="checkbox"/> Other medical conditions | _____ |



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

- How bad is your pain/irritation?  
0—1—2—3—4—5—6—7—8—9—10
- How frequent is your pain/irritation?  
0—1—2—3—4—5—6—7—8—9—10
- How bad is your numbness/tingling?  
0—1—2—3—4—5—6—7—8—9—10
- 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 CIRCLING the number that best describes your ability TODAY.

1. Rate Your Ability to Sit

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

2. Rate Your Ability to Stand:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

3. Rate Your Ability to Walk:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

4. Rate Your Ability to Bend Forwards:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

5. Rate Your Ability to Lift and Carry:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

6. Rate Your Ability to Participate in Your Normal Sport or Recreational Activities:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

7. Rate Your Ability to Work:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

8. Rate Your Ability to have Sexual Relations:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

9. Rate Your Ability to Sleep:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

10. Rate Your Overall Ability to Perform Your Normal Daily Activities:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
Completely able to do Half ability Completely unable to do

Who referred you to MotionCare?

Medical Doctor  Insurance provider  Physical Therapist  Chiropractor  Family  Friend

High School / College  Co-worker Other \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_