MotionCare®
Movement for a better life

Medical History

Date:

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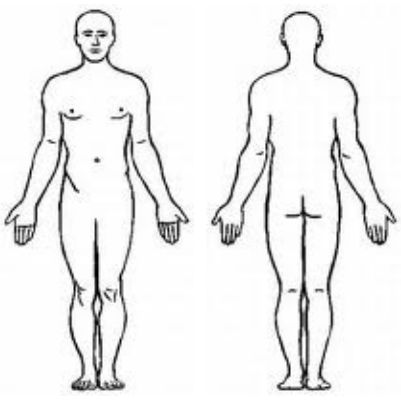
Name:

What condition brings you here?

Is your condition simply *pain*, or is it an *injury*?

Check any pertinent items, indicate where the pain/injury is from and list any associated medications/conditions.
(Pain/Injury causes: New, Previous, Work Related, Motor Vehicle Accident, Sports Injury)

	Pain/Injury cause	Associated Medications/Condidtions
○ 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 irritations and where it travels.
(0 indications no irritations – 10 indicates intolerable irritation)

	0	1	2	3	4	5	6	7	8	9	10
How bad is your pain/irritation?	○	○	○	○	○	○	○	○	○	○	○
How frequent is your pain/irritation?	○	○	○	○	○	○	○	○	○	○	○
How bad is your numbness/tingling?	○	○	○	○	○	○	○	○	○	○	○
How frequent is your numbness/tingling?	○	○	○	○	○	○	○	○	○	○	○

Functional Condition

List any lost work time:

List any activity/work restrictions:

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

(0 Completely able to do – 5 Half ability – 10 indicates intolerable irritation)

	0	1	2	3	4	5	6	7	8	9	10
Rate your ability to sit.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your ability to stand.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your ability to walk.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your ability to bend forwards.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your ability to lift and carry.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your ability to participate in your normal sport or recreational activities.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your ability to work.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your ability to have sexual relations.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your ability to sleep.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Rate your overall ability to perform your normal daily activities.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Who referred you to MotionCare?

☐ Medical Doctor ☐ Insurance provider ☐ Physical Therapist ☐ Chiropractor ☐ Family Friend

☐ High School / College ☐ Co-worker ☐ Other

Patient Signature_____ Date_____

Therapist Signature_____ Date_____