Motion Orthopaedics

Motionorthodocs.com

Please complete the following health questionnaire. We are concerned with your overall health, as well as your orthopedic problems. This information is confidential and will be reviewed with you by your doctor today. It is designed to help you recall your history and to provide details that will help in your diagnosis and treatment plan. Thank you.

Name: _____ Nickname: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Sex: _____

Are you: Right Handed ☐ Left Handed ☐ **Are you pregnant**? Yes ☐ No ☐

Who referred you: _____ Relationship: _____

Date of Injury/ Onset: _____ Description of job duties: _____

☐ Work Injury ☐ Auto Accident ☐ Acute Injury Currently Working: ☐ Light ☐ Part-Time ☐ Full ☐ Disabled ☐ Retired

Body part to be examined:

Shoulder	Right ☐	Left ☐	Both ☐
Elbow	Right ☐	Left ☐	Both ☐
Wrist/Hand	Right ☐	Left ☐	Both ☐
Hip	Right ☐	Left ☐	Both ☐
Knee	Right ☐	Left ☐	Both ☐
Ankle/Foot	Right ☐	Left ☐	Both ☐
Other _____	Right ☐	Left ☐	Both ☐

State of accident/injury:
☐ MO ☐ IL _____ Other(type above)

New Injury: ☐ Continued Problem: ☐ Second Opinion: ☐ Referral for Surgery: ☐

Brief description of the injury: _____

Is the condition getting: Better: ☐ Worse: ☐ Same: ☐

Rate your pain from 1 to 10 with 10 being the most painful: Now: _____ At its worst: _____

Location of pain:	Front ☐	Back ☐	Inside ☐
	Outside ☐	Deep ☐	Superficial ☐
	Radiating ☐	Whole Area ☐	Other: _____
Is the pain:	Constant ☐	Dull ☐	Aching ☐
	Intermittent ☐	Sharp ☐	Stabbing ☐
	Throbbing ☐	Tingling ☐	Burning ☐
Do you have:	Weakness ☐	Stiffness ☐	Loss of Motion ☐
	Locking ☐	Catching ☐	Popping ☐
	Grinding ☐	Giving way ☐	Other: _____

When do you experience it most? _____

Anything make it better? _____ Worse? _____

What treatments have you tried?

Rest	☐	Ice	☐	Compression	☐
Elevation	☐	Bracing	☐	Physical Therapy	☐
Exercise	☐	Chiropractic	☐	Acupuncture	☐
Massage	☐	Injections	☐	Cortisone	☐
Trigger Point	☐	Synvisc	☐	Other:	

Has anything helped? Yes ☐ No ☐ If yes, which? _____

Where were you first evaluated, for example: in an ER, an urgent care center, an occupational medicine center, or a doctor's office? _____

Have you been provided medications? Yes ☐ or No ☐ If yes, please list:

Have you had any x-rays, MRI's, or other tests? Yes ☐ or No ☐ If yes, please list:

Have you been recommended to have surgery? Yes ☐ or No ☐ If yes, please describe procedures and list dates:

Prior Injuries/ Traumatic Events to the same body part(s):
Have you sought medical care for the same body part? Yes ☐ or No ☐ If yes, please list:

Have you ever had a doctor/chiropractor/therapist/ or any other person in the allied medical field evaluate the same body part? Yes ☐ or No ☐ If yes, please explain:

Are you a student, where? _____ What grade? _____ Sports? _____

Coach/Trainer's Name: _____ Phone Number, if known: _____

Golf	☐	Tennis	☐	Soccer	☐	Baseball	☐	Football	☐
Wrestling	☐	Hockey	☐	Running	☐	Track/XC	☐	Lacrosse	☐
Basketball	☐	Hunting	☐	Skiing	☐	Bowling	☐	Hiking	☐
Softball	☐	Volleyball	☐	Field Hockey	☐	Weight Lifting	☐	Swimming	☐

Other: _____

I certify that this information is true and correct to the best of my knowledge. Please sign below.

_____ _____

Patient or Responsible Parent (if under 17 years old) Date

☐ By checking this box I certify & affirm my intent to sign this form electronically by typing my name above.