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:		Nicknam	e:	Date:		
Date of Birth:	Age:] Height: V	Veight: Se	ех:		
Are you: Right Handed	Left Handed	Are you pregnant?	Yes No			
Who referred you:			Relationship:			
Date of Injury/ Onset: Work Injury Au	Desc to Accident Acute In	ription of job duties: ury Currently Working:	Links Don't Time	F.·II	District of	Retired
Body part to be examine		ury Currently Working.	Light Part-Time	Full	Disabled	Reurea
Shoulder	Right	Left	Both State of acc		y:	
Elbow	Right	Left	Both MO	IL	Other(type a	bove)
Wrist/Hand	Right	Left	Both		•••	,
Hip	Right	Left	Both D			
Knee Ankle/Foot	Right	Left	Both D			
Other Other	Right Right	Left	Both Both			
Other	Right	Left	DOIII			
New Injury: Cor	ntinued Problem:	Second Opinion:	Referral for Surgery:			
Brief description of the i	njury:]					
Is the condition getting:	Better:	Worse:	Same:			
Rate your pain from 1 to	o 10 with 10 being the mo	ost 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 experienc	e it most?					
Anything make it better?	?	Wo	orse?			

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: Coach/Trainer's Name: Phone Number, if known: Soccer Baseball Football Saking Bowling Hunting Skiing Bowling Skiing Swimming Softball Volleyball Field Hockey Swimming Swimming	What treatments have you tried?	Rest		Ice		Compression		
Massage		Elevation		Bracing		Physical Therap	ру 🔲	
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 list: Have you a student, where? What grade? Sports?		Exercise		Chiropract	ic 🔲	Acupuncture		
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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 fyes, please list: Have you had any x-rays, MRI's, or other tests? Yes or No fyes, please list: Have you been recommended to have surgery? Yes or No fyes, 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 fyes, 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 fyes, please explain: What grade? Sports? Are you a student, where? Phone Number, if known: Golf Tennis Soccer Baseball Football Acrosse Baseball Football Hockey Running Hiking Soltball Weight Lifting Swimming Skiing Sowimming Skiing Swimming Skiing Swimming Swimming Stellar Source Swimming Swimming Swimming Sother:		Trigger Poir	nt 🔲	Synvisc		Other:		
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Yes or No figure 1 figure 1 figure 1 figure 2 field Hockey field Hocke	•	• • • • •	or No	☐ If yes, p	lease	list:]
Coach/Trainer's Name: Phone Number, if known:	·	pist/ or any oth	ner person	in the allied	l medi	cal field evaluate	the same boo	⊒ dy part? ☐
Golf Tennis Soccer Baseball Football Wrestling Hockey Running Track/XC Lacrosse Basketball Hunting Skiing Bowling Hiking Softball Volleyball Field Hockey Weight Lifting Swimming Other:	Are you a student, where?		What	grade?		Sports?]
Wrestling Hockey Running Track/XC Lacrosse Basketball Hunting Skiing Bowling Hiking Softball Volleyball Field Hockey Weight Lifting Swimming Other:	Coach/Trainer's Name:	Phone Number, if known:						
certify that this information is true and correct to the best of my knowledge. Please sign below.	Wrestling Hockey Basketball Hunting	Running Skiing	Py	Track/XC Bowling		Lacrosse [Hiking [
	I certify that this information is true and correct	to the best of	my knowle	dge. Pleas	e sigr	ı below.		_
								_

Patient or Responsible Parent (if under 17 years old)

Date