MOTION DYNAMICS PHYSICAL THERAPY

EXCELLENCE IN ORTHOPEDIC MANUAL THERAPY AND SPORTS REHABILITATION

MEDICAL HISTORY QUESTIONNAIRE

Your medical history is an essential component of your initial evaluation and we ask that you complete all applicable sections. If you need assistance, please feel free to ask our registrar. If you are unsure of any information, please leave it blank. Your therapist will review your responses with you during your evaluation.

Name:____ Date:________________

E-mail Address____

Marital Status:___________ Age:_________ # of Children:___________

Occupation:____

Presently at Work?____________ If not, last day worked:______________________

Present Leisure Activities:

____

____

____

Activities prevented because of pain: ____

____

____

Current Weight_____________ Gain/Loss over past year: _____________

FAMILY HISTORY

Do your parents or siblings have any of the following?

	Yes	No	Relationship
Diabetes	____	____	___________
High Blood Pressure	____	____	___________
Cancer	____	____	___________
Heart Disease	____	____	___________
Stroke	____	____	___________
Arthritis	____	____	___________
Others	____	____	___________

Do you engage in any of the following?

	Yes	No	Describe type and frequency
Exercise	___	___	_______________________
Smoking	___	___	_______________________
Alcohol	___	___	_______________________
Coffee/Caffeine	___	___	_______________________

Operations/Hospitalizations: (description & date)

____

____

____

____

List all medications you take (identify all prescription medications and over-the-counter medications including vitamins, laxatives, hormones, pain pills, sedatives, antacids). List the dosage and how often you take the medication. (daily, three times per day, etc).

MEDICATION/ DOSAGE

____

____

Do you have any allergies? Please list

____

____

REVIEW OF SYSTEMS:
Have you had or told you had:

	YES	NO	COMMENTS
HEAD/NECK:			
Headaches	_______	_______	____________
Change in Vision or Hearing	_______	_______	____________
Dental/Gum Problems	_______	_______	____________
Neck Swelling/ Lumps	_______	_______	____________
Trouble Swallowing	_______	_______	____________
CARDIOVASCULAR:			
High Blood Pressure	_______	_______	____________
Blood Clots	_______	_______	____________
Chest Pain (angina)	_______	_______	____________
Varicose Veins	_______	_______	____________
Heavy Chest Pressure	_______	_______	____________
Coronary or Other Heart Disease	_______	_______	____________
Irregular Heart Beat	_______	_______	____________
Palpitations	_______	_______	____________
Leg/Ankle Swelling	_______	_______	____________
Pancreas Disease	_______	_______	____________
Cramps in legs while walking	_______	_______	____________
At night	_______	_______	____________
Calf Tenderness	_______	_______	____________
RESPIRATORY:			
Asthma	_______	_______	____________
Lung Disease	_______	_______	____________
Unusual Shortness of Breath	_______	_______	____________
Chronic Cough	_______	_______	____________
Coughing up Blood/Sputum	_______	_______	____________
Production	_______	_______	____________
Wheezing	_______	_______	____________
DIGESTIVE:			
Indigestion/Heartburn	_______	_______	____________
Ulcer Disease	_______	_______	____________
Repetitive Nausea/Vomiting	_______	_______	____________
Intestinal Disease	_______	_______	____________
Abdominal Pain	_______	_______	____________
Black Stools	_______	_______	____________
Blood in Stools	_______	_______	____________
Liver Disease	_______	_______	____________

	YES	NO	COMMENTS
Diarrhea	_______	_______	____________
Gall Bladder Disease	_______	_______	____________
Constipation	_______	_______	____________
Milk Intolerance	_______	_______	____________
Egg Intolerance	_______	_______	____________
GENITOURINARY:			
Kidney Disease	_______	_______	____________
Urinary Problems/Infection	_______	_______	____________
Frequent Urination	_______	_______	____________
Nighttime Urination	_______	_______	____________
Urgency	_______	_______	____________
Releasing urination with coughing or sneezing	_______	_______	____________
Blood in Urine	_______	_______	____________

NEURO/PSYCHE:

Dizziness ______ ______ ___________
Fainting ______ ______ ___________
Seizures ______ ______ ___________
Numbness/Tingling ______ ______ ___________
Depression ______ ______ ___________
Psychiatric Disorder ______ ______ ___________

MUSCULOSKELETAL:

Gout ______ ______ ___________
Joint Pain/Swelling ______ ______ ___________
Back Pain ______ ______ ___________
Arthritis ______ ______ ___________
Weakness, Arms/Legs ______ ______ ___________
Numbness/Tingling ______ ______ ___________

OTHER:

Diabetes ______ ______ Diet Controlled____
Insulin Dependent___
Other_____________

Easy Bruising/Bleeding ______ ______ ___________
High Cholesterol/Triglycerides ______ ______ ___________
Thyroid Problem ______ ______ ___________
Unusual Hair Growth/Loss ______ ______ ___________
Heat Cold/Intolerance ______ ______ ___________
Insomnia ______ ______ ___________
Daytime Drowsiness ______ ______ ___________

PAIN SURVEY

It is difficult at best to describe pain. This survey attempts to identify the major parameters of your pain: Location, Intensity, Frequency, Quality, and Effect on Activity. Please follow the directions so that we may have an understanding of these parameters for every area of pain that you are currently experiencing.

1. Location
   Indicate where your pain is located by placing a circle where the pain originates and a line to where it radiates, on the diagram.

2. Intensity
   For each location of pain identified , please grade the intensity from 1 to 5 in the spaces provided for the body section where the pain originates.
   - 1-2=mild/not limiting function
   - 3-4=discomforting/slightly limiting function
   - 5-6=distressing/limiting function
   - 7-8=horrible/disabling
   - 9-10=excruciating/severely disabling

3. Frequency
   How does your pain change with time? For each location of pain, please circle one of the following words which best describes the frequency of your pain for each body section where the pain originates:

Intensity:___________
Frequency: (circle) constant / frequent / occasional / rarely

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Frequency: (circle) constant / frequent / occasional / rarely

Intensity:______________
Frequency: (circle) constant / frequent / occasional / rarely

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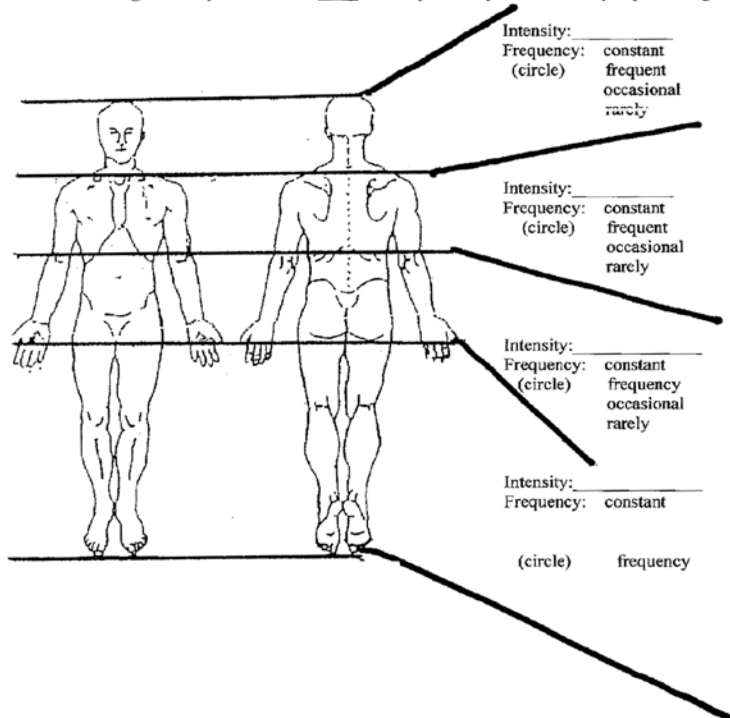
Frequency: (circle) constant / frequent / occasional / rarely



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3. Frequency
   How does your pain change with time? For each location of pain, please circle one of the following words which best describes the frequency of your pain for each body section where the pain originates:
   - Constant
   - Frequent
   - Occasional
   - Rarely

Intensity:___________
Frequency: (circle) constant / frequent / occasional / rarely

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Intensity:___________
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(circle) frequency