MOTIVE
SPORTS & PHYSICAL THERAPY

## MEDICAL HISTORY

Check each of the topics that relate to your past medical history:

| | | |
|---|---|---|
| ☐ Anemia | ☐ A Pacemaker | ☐ Allergies |
| ☐ Back Pain | ☐ Chest Pain / Angina | ☐ Asthma |
| ☐ Bronchitis | ☐ Blood Clot / Embolism | ☐ Bowel/Bladder Problems |
| ☐ Dizziness or Faintness | ☐ Coronary Heart Disease | ☐ Currently Pregnant |
| ☐ Epilepsy / Seizures | ☐ Drinks Alcohol | ☐ Emphysema |
| ☐ Heart Attack | ☐ Gout | ☐ Hearing Problems |
| ☐ Kidney Disease | ☐ Hernia | ☐ High Blood Pressure |
| ☐ Severe / Frequent Headache | ☐ Parkinson's | ☐ Pneumonia |
| ☐ Stroke / TIA | ☐ Sleeping Problems | ☐ Tobacco Use |
| ☐ Vision Problems | ☐ Thyroid Problems | ☐ Varicose Veins |
| ☐ Women's Health Issues | ☐ Weakness | ☐ Weight Loss / Energy Loss |

Check each of the body parts below that relate to your past medical history and check either *both*, *left*, or *right* sides:

| | | | |
|---|---|---|---|
| ☐ **Ankles** | ☐ *Both* | ☐ *Left* | ☐ *Right* |
| ☐ **Elbows** | ☐ *Both* | ☐ *Left* | ☐ *Right* |
| ☐ **Hips** | ☐ *Both* | ☐ *Left* | ☐ *Right* |
| ☐ **Legs** | ☐ *Both* | ☐ *Left* | ☐ *Right* |
| ☐ **Knees** | ☐ *Both* | ☐ *Left* | ☐ *Right* |
| ☐ **Shoulders** | ☐ *Both* | ☐ *Left* | ☐ *Right* |
| ☐ **Wrists** | ☐ *Both* | ☐ *Left* | ☐ *Right* |

Check each box if you have a history of the following: (**Please circle**)

| | | |
|---|---|---|
| ☐ **Joint Replacement** | Location(s):_____ | **R L Both** |
| ☐ **Pins or Metal Implants** | Location(s):_____ | **R L Both** |
| ☐ **Arthritis** | Location(s):_____ | **R L Both** |
| ☐ **Numbness/Tingling/Neuropathy** | Location(s):_____ | **R L Both** |

Check any of the following that apply to you:

| | | |
|---|---|---|
| ☐ Complex Regional Pain Syndrome | ☐ Infectious Disease | ☐ Incontinence |
| ☐ Diabetes, Type II | ☐ Diabetes, Type I | ☐ My home has stairs |
| ☐ I have received PT treatment at home | ☐ I am a caregiver for someone else | ☐ Other Surgery |
| ☐ I use a cane | ☐ I live alone | ☐ Vertigo/Balance |
| ☐ I use a wheelchair | ☐ I use a walker | |

**Does your diagnosis impact your ability to do your job?**

- ☐ I am retired
- ☐ It prevents me from working
- ☐ I can only work part-time
- ☐ I can work, but with great difficulty
- ☐ I can work, with minor difficulty
- ☐ No impact on my work
- ☐ Not applicable

**Does your diagnosis impact your ability to attend school?**

- ☐ It prevents me from attending school
- ☐ I am in school, but it has a big impact
- ☐ I am in school, but it has a minor impact
- ☐ School is normal, but I can't participate in sports
- ☐ School is normal, no impact
- ☐ Not applicable

**How often do you exercise per week?**

- ☐ Never
- ☐ Usually once
- ☐ Usually twice
- ☐ Usually three times
- ☐ 4 or more times

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Does your daily routine, or work, aggravate your injury?

- ☐ No
- ☐ I am **unable to participate** in my normal routines or work
- ☐ My routine/work usually impacts my injury **1 day per week**
- ☐ My routine/work aggravates my injury about **2 days per week**
- ☐ My routine/work aggravates my injury about **3 days per week**
- ☐ My routine/work aggravates my injury **every day, but I try to cope**

**MEDICATIONS**

Please use the space below to list all medications you are currently taking **along with the dosage**:

- ☐ I am not taking any medications
- ☐ My medications list was scanned in
- ☐ See my medications written in space below:

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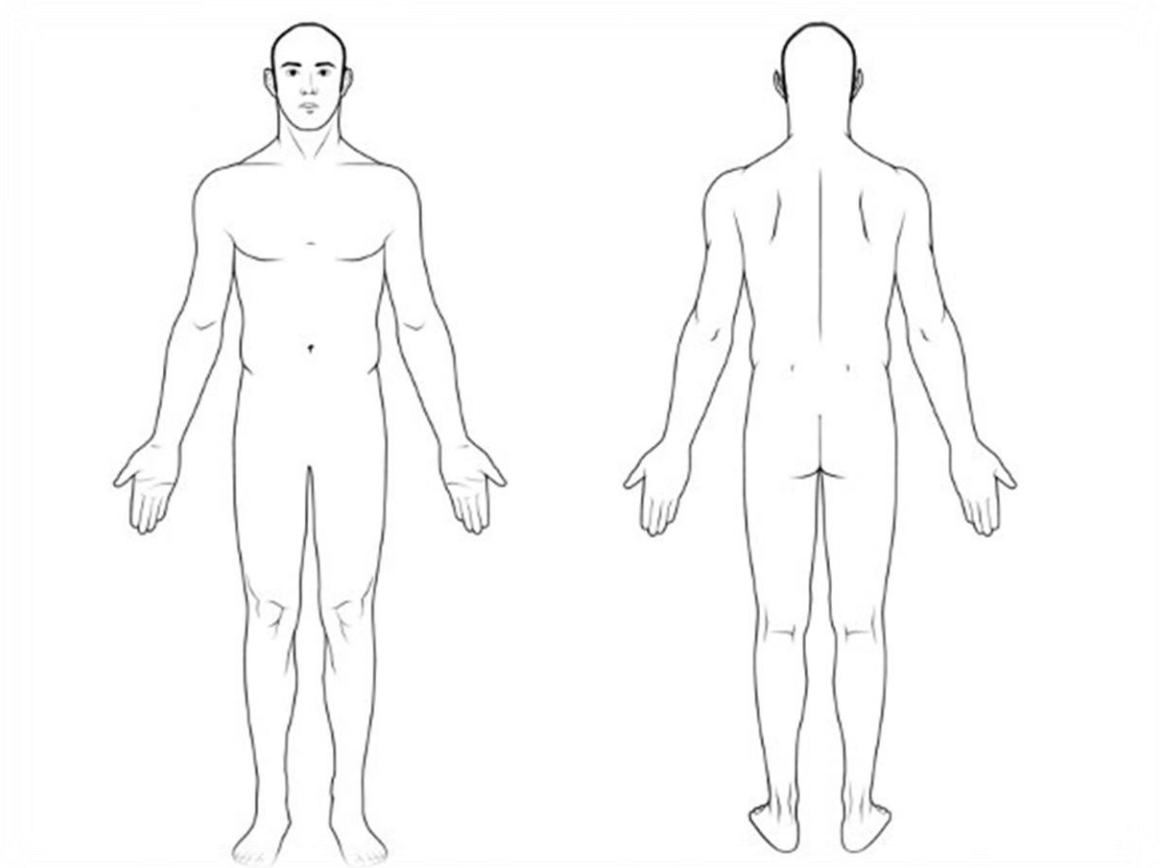
Please indicate with an **X** on the body diagram the area(s) that prompted today's visit?



Is this current problem a recurrence of a prior injury? Please circle **Yes** **No** If Yes, what year was prior injury? _____

How would you describe the pain? **Please check all that apply**

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Cramping
- ☐ Deep
- ☐ Dull
- ☐ Heavy
- ☐ Pins and Needles
- ☐ Stabbing
- ☐ Throbbing
- ☐ Variable
- ☐ Weak

Using a scale of **0 to 10** *(0 = no pain and 10 = worst pain you've ever felt)*

☐ What was your pain level when the injury first occurred?
**Please circle** **0 1 2 3 4 5 6 7 8 9 10**

☐ What is your pain level when it is at its worst?
**0 1 2 3 4 5 6 7 8 9 10**

☐ What is your pain level when it is at its best?
**0 1 2 3 4 5 6 7 8 9 10**

What makes your pain worse? **Please check all that apply**

- ☐ Reaching back
- ☐ Lying flat
- ☐ Getting up out of bed
- ☐ Dressing and grooming
- ☐ Cooking
- ☐ Carrying items
- ☐ Climbing stairs
- ☐ Twisting
- ☐ Lifting anything
- ☐ Lifting heavy weights
- ☐ Pulling
- ☐ Raising arm overhead
- ☐ Looking up/down
- ☐ Walking

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What relieves your pain? **Please check all that apply**

- ☐ Ice
- ☐ Heat
- ☐ Stretching
- ☐ Exercise
- ☐ Pain medication
- ☐ Lying flat
- ☐ Avoiding activity
- ☐ Nothing

Please list the following:

Height_____

Weight_____

Have you had any falls in the past year? **YES** **NO**

If Yes, how many?_____

If Yes, were you injured? **YES** **NO**

Regarding tobacco usage, check the following that apply:

- ☐ Smoke tobacco
- ☐ Chew tobacco
- ☐ Snuff tobacco
- ☐ All of the above
- ☐ None of the above

Have you ever received advice or counseling to help you stop using tobacco?

- ☐ Yes
- ☐ No