MOVEMENT ORTHOPEDICS
GET BACK TO IT.

43475 Dalcoma Dr. Suite 250
Clinton Township, MI 48038
(586) 436-3785 | www.movementortho.com

NEW PATIENT — MEDICAL QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Date:** _____ **Age:** _____ ☐F ☐M

Dominant Hand: ☐ L ☐ R **Height:** _____ / _____ **Weight:** _____ **Did you bring X-rays?** ☐ Y ☐ N

Who requested this visit? _____ ☐ Attorney ☐ Self

CHIEF COMPLAINT

Main reason for this visit: ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other: _____

AFFECTED BODY PART — MARK ALL THAT APPLY

Upper Body		
☐ Neck →	☐ R arm ☐ L arm ☐ Neither	
☐ Shoulder	☐ L	☐ R
☐ Elbow	☐ L	☐ R
☐ Arm	☐ L	☐ R
☐ Wrist	☐ L	☐ R
☐ Hand	☐ L	☐ R
☐ Finger	T 2 3 4 5 ☐ L ☐ R	

Lower Body		
☐ Back →	☐ R leg ☐ L leg ☐ Neither	
☐ Hip	☐ L	☐ R
☐ Knee	☐ L	☐ R
☐ Leg	☐ L	☐ R
☐ Ankle	☐ L	☐ R
☐ Foot	☐ L	☐ R
☐ Pelvis	☐ L	☐ R
☐ Toe	B 2 3 4 5 ☐ L ☐ R	

ONSET & HISTORY

How long ago did it start? Days: _____ Weeks: _____ Months: _____ Years: _____
Had a problem like this before? ☐ Y ☐ N
Check ONE box that describes how your problem started, then answer below:

☐	**No Injury**	Onset: ☐ Gradual ☐ Sudden Why did it start? _____
☐	**Injury** (not auto/work)	☐ Accident ☐ Sport Date: _____ Where/How: _____
☐	**Injury at Work**	Date: _____ From: ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach
☐	**Work Related** (no injury)	Date: _____ How did your job cause the problem? _____
☐	**Auto Accident**	Date: _____ How was your car hit? _____

PAIN & SYMPTOMS

Pain (0–10): 0 1 2 3 4 5 6 7 8 9 10 **Quality:** ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning
Pain is: ☐ Constant ☐ Intermittent **Wakes you from sleep?** ☐ Y ☐ N **Since onset:** ☐ Getting better ☐ Getting worse ☐ Unchanged
Do you have: ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of bladder/bowel control
What makes it worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing

What makes it better? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other: _____

PRIOR TREATMENT

Medications for this problem: _____
Prior treatments? Injection ☐Y ☐N Brace ☐Y ☐N Physical Therapy ☐Y ☐N Cane/Crutch ☐Y ☐N

Seen in E.R.? ☐Y ☐N Which E.R.: _____ Date: _____ **Here because of E.R. visit?** ☐Y ☐N Who saw you? _____
Tests/scans for this problem: ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)
Prior surgery in this area? ☐Y ☐N

Procedure #1: _____ Surgeon: _____ City: _____ Date: _____

Procedure #2: _____ Surgeon: _____ City: _____ Date: _____

WORK STATUS

Current status: ☐ Regular ☐ Light Duty (How long? _____) ☐ Not working due to this problem ☐ Disabled ☐ Retired ☐ Student

Last date at regular job: _____ **Receiving/applying for:** Disability ☐Y ☐N Work Comp ☐Y ☐N Unemployment ☐Y ☐N

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NEW PATIENT — MEDICAL QUESTIONNAIRE (CONTINUED)

Name: _____ **DOB:** _____ **Appt Date:** _____

REVIEW OF SYSTEMS — CIRCLE ANY CONDITION YOU CURRENTLY HAVE

System	Conditions				None
M/S	Rheumatoid Arthritis	Gout	Back Pain	Osteoporosis Fracture — which bone? _____	☐
GI	Heartburn	Ulcers	Nausea	Vomiting Blood in Stool	☐
Endocrine	Frequent Thirst	Frequent Urination	Always Hot or Cold		☐
Constitutional	Weight Loss	Frequent Fever	Loss of Appetite		☐
Eye	Blurred Vision	Double Vision	Vision Loss		☐
ENT	Hearing Loss	Hoarseness	Trouble Swallowing		☐
Cardiovascular	Chest Pain	Palpitations			☐
Respiratory	Chronic Cough	Shortness of Breath			☐
GU	Painful Urination	Blood in Urine	Kidney Problems		☐
Skin	Frequent Rashes	Skin Ulcers	Psoriasis		☐
Neuro	Headaches	Dizziness	Seizures		☐
Psych	Drug/Alcohol Problem	Depression	Sleep Disorder		☐
Heme	Easy Bleeding	HIV/AIDS	Hemophilia		☐

ALLERGIES — LIST ALL ALLERGIES (MEDICATIONS AND FOOD) ☐ NONE

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

CURRENT MEDICATIONS — LIST ALL WITH STRENGTH ☐ NONE

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

9. _____ 10. _____ 11. _____ 12. _____

PAST MEDICAL HISTORY — CIRCLE ANY CONDITIONS YOU HAVE HAD ☐ NONE OF THE BELOW

Asthma	Diabetes	Heart Attack (year: ____)	Stroke
Aspirin Sensitivity	Kidney Failure	Heart Failure	Cancer — location: _____
Stomach/Bleeding Ulcer	Hepatitis	High Blood Pressure	
Liver Disease	COPD	Notes: _____	

Stomachache taking anti-inflammatories (NSAIDs)? Which? _____

Blood clots requiring blood thinners? ☐ Y ☐ N When? _____

PAST SURGICAL HISTORY ☐ NONE

What operations have you had? When? _____

Reaction to anesthesia? ☐ Y ☐ N

PAST HOSPITALIZATIONS (NOT FOR SURGERY) ☐ NONE

FAMILY HISTORY ☐ NONE

Have direct relatives had: ☐ Hemophilia _____ ☐ High Blood Pressure _____ ☐ Diabetes _____ ☐ Rheumatoid Arthritis _____

SOCIAL HISTORY

Smoker? ☐ Y ☐ N Packs/day: _____ **Alcohol:** ☐ None ☐ Social ☐ Daily / # per day: _____ **Illicit drugs?** ☐ Y ☐ N

Marital Status: ☐ M ☐ S ☐ D ☐ W **People in household:** _____ **Occupation:** _____ ☐ Student

Employer: _____ **Like your job?** ☐ Y ☐ N **Plan to be working in 6 months?** ☐ Y ☐ N

The information on these forms is accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____