Steven J Morgan, MD
Wade R. Smith, MD
Melissa Copeland, PA-C
Megan Cronin, PA-C

Practitioner Initials:_____
Date:_____

MOTUS PATIENT HISTORY

(Please print and fill out completely)

Today's Date:_____ **NAME:**_____

Age:_____ **Height:**_____ **Weight:**_____ **Hand Dominance:** ☐ **Right** ☐ **Left** ☐**Ambidextrous**

Occupation: _____

Referring Physician: _____ **Phone:**_____

Date of injury: _____

HISTORY OF PRESENT INJURY (Why are you here today?)

How did it happen: ☐ **Fall** ☐**Auto Accident** ☐**Other:**_____

Injury to: ☐**Left** ☐**Right** ☐**Arm** ☐**Ankle** ☐**Leg** ☐**Hip** ☐**Wrist** ☐**Other:**_____

What type of treatment have you received?: ☐**Splint** ☐**Surgery** ☐**Other:** _____

What is your level of pain today? (1= none, 10= severe) Please circle: 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS: (check If you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have problems check the "none" box)

Constitutional: ☐**None** ☐**Weight loss** ☐**Other:** _____
Cardiovascular: ☐**None** ☐**Chest pain** ☐**Other:** _____
Respiratory: ☐**None** ☐**Asthma** ☐**Other:** _____
Gastrointestinal: ☐**None** ☐**Ulcers** ☐**Other:** _____
Musculoskeletal: ☐**None** ☐**Arthritis** ☐**Joint pain** ☐**Other:**_____
Skin: ☐**None** ☐**Rash** ☐**Other:** _____
Neurological: ☐**None** ☐**Weakness** ☐**Numbness** ☐**Other:** _____
Psychiatric: ☐**None** ☐**Depression** ☐**Anxiety** ☐**Other:** _____
Endocrine: ☐**None** ☐**Diabetes** ☐**Other:** _____
Hematology: ☐**None** ☐**Bleeding** ☐**Blood Clots** ☐**Other:** _____

MEDICAL HISTORY: (Have you been diagnosed with any of the following)
☐**Cancer** ☐**Chemical dependency and/or Alcoholism** ☐**Emphysema** ☐**Heart disease** ☐**Hepatitis** ☐**HIV**
☐**High blood pressure** ☐**Liver disease** ☐**Osteoporosis** ☐**Rheumatoid arthritis** ☐**Stroke/Seizures**
☐**Other:**_____

PAST SURGICAL HISTORY:
(Please check on previous surgical procedures, list the date and describe surgery)
☐**Appendectomy** ☐**Heart Surgery** ☐**Hernia repair** ☐**Spine Surgery** ☐**Total Joint replacement** ☐**Fracture repair**
☐**Other (Explain):**_____

FAMILY HISTORY: ☐**Heart Disease** ☐**Arthritis** ☐ **Other (explain):**_____
_____.

SOCIAL HISTORY:
Tobacco Use: ☐**Yes** ☐**No** **Alcohol Use:** ☐**Yes** ☐**No** **Drug Use:** ☐**Yes** ☐**No Type:** _____

ALLERGIES:
Medications - ☐**Yes** ☐**No Please list:**_____

MEDICATIONS: Please list all medications you are currently taking including prescription medications, over the counter medications, vitamins and supplements.

Medication	Dosage	Frequency

Signature:_____**Date:**_____

Print Name:_____