Reason for Visit – QUESTIONNAIRE II

MOVEWELL

Name: _____ Date: _____
First Last D.M.Y

Reason for consulting Movewell (please check all that apply):

○ For Optimizing Health & Performance ○ Nutrition Counseling ○ Pain ○ Sports Injury ○ Accidents/Trauma

Describe what brought you to Movewell:

_____

Date of onset: _____ Have you had X-rays / CTs / MRIs taken of the aforementioned area? ○ Yes ○ No

Have you had this problem in the past? ○ Yes ○ No If yes, is it the ○ Same ○ Worse ○ Better than before

Describe the pain: ○ Achy/Throbbing/Stabbing/Burning/Shooting ○ Dull/Sharp ○ Deep/Superficial

What % of the day do you have the pain? ○ 0-25% ○ 26-50% ○ 51-75% ○ 76-100%

Does it affect your regular activities? ○ Yes ○ No If yes, how so? _____

Severity of pain on a scale from 0 (none) - 10 (worst imagined): Today? _____ At Time of injury? _____

When do you feel the best? ○ Morning ○ Afternoon ○ Evening ○ Night

When do you feel the worst? ○ Morning ○ Afternoon ○ Evening ○ Night

Have you seen anyone else for this problem? ○ Yes ○ No If yes, who? _____

What profession? ○ Medical Doctor ○ Chiropractor ○ Nutritionist ○ Trainer ○ Physio ○ Other

If you would like us to contact the professionals for your previous treatment records, please give us as much information as possible (phone, address, name, city, email etc.): _____

_____

How have you treated yourself for this condition? ○Medication ○Massage ○Ice/Heat ○Exercise ○Stretching ○Other

Please list anything that makes the condition better: _____

Please list anything that makes the condition worse: _____

Are you currently taking any medications, supplements, muscle relaxer? Please list the reason, dosage and name:

_____

_____

Do you follow a specific nutrition plan/diet? ○ Yes ○ No If yes, what does it contain, including goals?

_____

_____

Do you have allergies? ○ Yes ○ No If yes, to what? _____

If yes, what do you do to prevent or alleviate symptoms? _____

I have completed this form to the best of my ability and discussed the information with Movewell professionals. I understand that they rely upon this information to make treatment recommendations.

_____ _____

Patient Signature
(If the patient is not yet 18 years old, a parent must sign.)

Movewell® – Martin Strietzel