Occupational & Hand Therapy Specialists, Inc.

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PATIENT HISTORY FORM

PATIENT NAME: _____ Today's Date: _____

***REFERRING DOCTOR*:** _____ ***FAMILY DOCTOR*:** _____

Hand Dominance: □ Right □ Left Age: _____ Date of Injury: _____

How did you hear about our services? □ Doctor □ Nurse practitioner □ Chiropractor □ Friend/family
□ Telephone Book □ Internet □ Other: _____

**** WHEN IS YOUR NEXT DOCTOR APPOINTMENT? Date: _____ Time: _____**

WORK INFORMATION

Are you currently employed? □ Yes □ No *Employer Name: _____
What is your job title? _____
What are your job duties/responsibilities? _____

What is your work status? □ Full-duty □ Full-time □ Part-time □ Restrictions □ Retired
□ Light-duty □ One-handed □ Off-duty □ Disability □ Student

PAST MEDICAL HISTORY

Please circle any past or current medical problems you may have:

Cardiac Heart Failure
Pacemaker
Cardiovascular Disease
COPD
Irregular Heart rate
Other (please list): _____

Cancer
High Blood Pressure
Diabetes
Gout
Arthritis

Stroke
Head Injury
Neck or Back pain
Current Height _____ Feet _____ Inches
Current Weight _____ Pounds

Please check if you are a □ non-smoker □ smoker

Do you feel safe in your home: □ Yes □ No

During the past month have you been feeling down, depressed or hopeless? □ Yes* □ No

During the past month have you had a lack of interest or pleasure in doing things? □ Yes* □ No

*Is this something you would like help with or additional information for? □ Yes □ No

Please list any previous neck, shoulder, arm, and/or hand surgeries and/or injuries:_____
_____

Do you have any metal implants or artificial joints? □ Yes □ No

Do you have any allergies? Please specify: _____

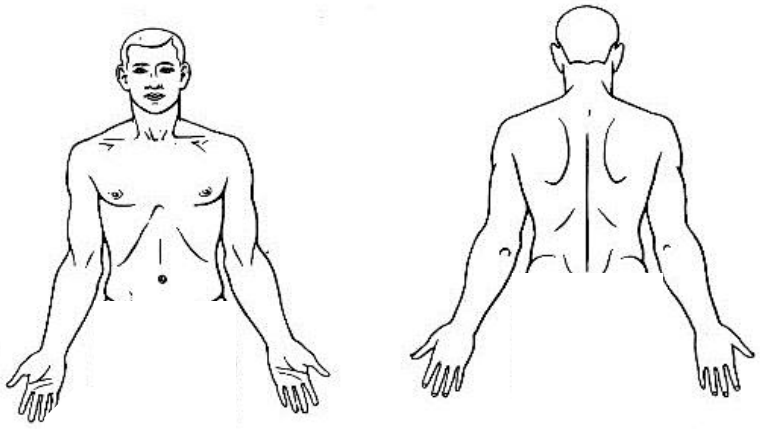
Please list all medications you are currently taking: _____
_____

Have you had any of the following tests performed for your current problem/condition:

Test			***Results:***
X-rays	□ Yes	□ No	_____
Nerve conduction test	□ Yes	□ No	_____
EMG	□ Yes	□ No	_____
CT Scan	□ Yes	□ No	_____
MRI	□ Yes	□ No	_____

SYMPTOMS:

Please use this diagram to circle any problem areas:



PAIN

On a scale of 0 – 10, circle the number that best describes the intensity of your worst pain in the last week.
0 = no pain, to 10 = worst pain you could imagine.

0 1 2 3 4 5 6 7 8 9 10

TELL US ABOUT YOUR CURRENT CONDITION…

Date of injury: _____

Date of surgery: _____

What happened? Briefly describe your current problem/symptoms: _____

_____

Have you ever had these symptoms before? When? _____

Previous treatment for this problem? _____

What makes it better? _____

What makes it worse? _____

Have you tried any braces and/or splints? _____

How does this impact your life and what can't you do as a result? _____

_____

What hobbies/recreational activities do you enjoy? Are you having any difficulties performing these activities?

_____

What are your goals in coming to therapy? _____

_____

X_____ _____

Patient / Guardian Signature **Date**

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