Occupational & Hand Therapy Specialists, Inc.

1493 South Queen Street
York PA 17403
Phone: (717) 854-2029

PATIENT HISTORY FORM

PATIENT NAME: _____Today's Date: _____

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

Hand Dominance: □ Right □ Left Age: _____

**** 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

Seizures
Stroke
Osteoporosis
Head Injury
Neck or Back pain

Height ____Feet ____Inches
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 allergies? Please specify: _____

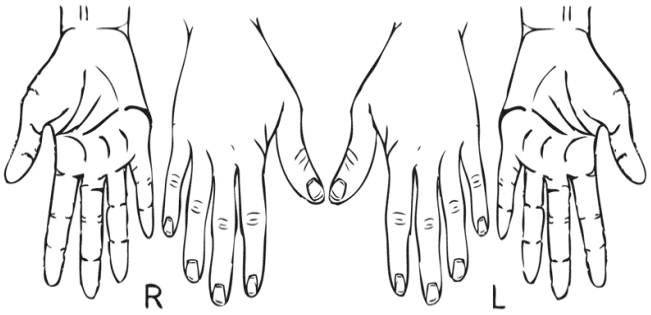
_____

Please list all medications you are currently taking: _____

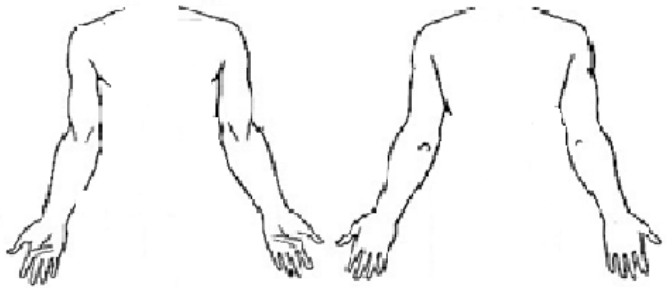
_____

SYMPTOMS:

Please use this diagram to circle any problem areas:



Front *Back*



PAIN

On a scale of 0 – 10, fill in the number that best describes your pain. **0- None 5- Moderate 10- Extreme.**

At Worst: _____ Current: ____ At Best: ____

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	_____
MRI	□ Yes	□ No	_____

Which of the following **BEST** describes your pain: (**CHOOSE ONE ONLY**)

DULL/ACHY **SHARP** **NUMBNESS/TINGLING** **CONSTANT** **THROBBING**

TELL US ABOUT YOUR CURRENT CONDITION:

Date of injury (If ongoing, about when did it start): _____ Date of surgery: _____

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

_____

How does this impact your daily activities? _____

_____

Previous treatment for this problem? _____

Have you tried any braces and/or splints? _____

Please list any recreational activities/hobbies you may have: _____

_____

LIST ALL GOALS FOR THERAPY: _____

_____

_____

X_____ _____

Patient / Guardian Signature **Date**

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