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Hand Therapy
Orthopaedic Rehabilitation
Orthotic Center

SPECIALISTS IN THE TREATMENT OF TRAUMATIC HAND INJURY, RECONSTRUCTIVE SURGERY, WORK AND SPORTS RELATED INJURY

Medical History

PATIENT:_____DATE:_____

Previous Medical History

PLEASE CHECK THE FOLLOWING IF YOU HAVE HAD:

___ Angina
___ Heart Attacks
___ Osteoporosis
___ Heart Disease
___ Neck Injuries
___ Cancer
___ Stroke
___ Fractures (broken bones)
___ High Blood Pressure
___ Heart Surgery
___ Back Injuries
___ Lung Disease
___ Tumors
___ Whiplash
___ Joint Strains
___ Diabetes
___ Circulatory Problems
___ Muscle Strains
___ Arthritis
___ Allergies
___ Epilepsy
___ Gastrointestinal Problems

PLEASE CHECK THE FOLLOWING IF YOU HAVE RECENTLY EXPERIENCED:

___ Headaches
___ Muscular Pain with Exertion
___ Falls
___ Tremors
___ Muscular Pain at Rest
___ Difficulty Sleeping
___ Constant Pain Unrelieved by Rest / Movement
___ Shortness of Breath
___ Dizziness
___ Balance Problems
___ Unusual Fatigue
___ Unusual Weakness
___ Blurred / Double Vision
___ Unusual Skin Coloration
___ Unexplained Weight Loss
___ Tingling, Numbness, or Loss of Feeling
___ Pain with Coughing or Sneezing
___ Change in Bowel and Bladder Habits

Diagnostic Tests

PLEASE CHECH THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN PERFORMED:

___ X-RAYS DATE:_____ RESULTS: _____
___ MRI DATE: _____ RESULTS: _____
___ EMG/NCV DATE: _____ RESULTS: _____

Current Medications

___ PRESCRIPTIONS _____ _____
___ OVER THE COUNTER _____ _____
___ NOT CURRENTLY TAKING MEDICATIONS

Main Complaints

_____
_____

Functional Limitations

_____
_____

Pain Levels

PLEASE RATE YOUR PAIN WHERE 0 = NO PAIN AND 10 = MAXIMUM PAIN: _____

PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBES YOUR PAIN:

___ CONSTANT
___ INTERMITTENT
___ PAIN UPON WAKING
___ INCREASING
___ DECREASING
___ OCCASIONAL
___ NIGHT PAIN
___ STIFFNESS
___ STATIC
___ DULL / ACHY PAIN
___ SHARP PAIN

PAIN IS AGGRIVATED BY:

_____

PAIN IS EASED BY:

_____

Patient Signature: _____