

Medical Questionnaire – Hand Therapy

Patient Name _____ **Date** _____

1. What problem or diagnosis brings you to this Physical Therapy office? _____
2. To the best of your knowledge, what was the date of your injury or surgery? ____/____/____
3. If this was an injury, please check the appropriate box.
 Motor vehicle accident Work Injury Sports Unknown Other (please describe) _____
4. I have had the following tests: X-ray MRI CT EMG Other _____
5. Do you have any numbness or tingling? Yes No
6. Are you Right Handed Left Handed?
7. What is your occupation? _____
8. Rate your pain on a scale from 0 to 10 with 0 = NO PAIN and 10 = WORST PAIN you can imagine.
 The best it has been since the injury _____. The worst it has been since the injury _____. Your Pain today _____.
9. What makes your pain feel BETTER? _____
10. What makes your pain feel WORSE? _____
11. Is your pain affecting your ability to sleep through the night? Yes No
12. What do you hope to gain from hand therapy? _____

Medications

Current Medications: _____

Current Vitamins/Supplements: _____

Medical History (Check any that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Chest/Abdominal Surgery | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Severe Night Pain |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Traumatic Injury/MVA |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menopause | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraine Headaches | _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Major Spinal Injury | <input type="checkbox"/> Previous Hand Surgeries: _____ |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Fractures | <input type="checkbox"/> MRSA | _____ |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Frequent Falls | <input type="checkbox"/> Osteoporosis | Month/Year: ____/____ |
| <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Pacemaker/Nitroglycerin | _____ |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Poor Circulation/Raynaud's | Month/Year: ____/____ |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | |

Signature _____ Date _____