Hand Center of Oregon, Inc.

Please fill out this form as completely as possible. It will assist your therapist in developing a plan of care for you. If you have any questions, please feel free to ask for assistance. This information will be kept confidential.

Name: _____ Date of Birth: _____

Occupation: _____ Hobbies: _____

Most Recent Date of Injury
or Onset of Symptoms: _____ Date of Initial Dr. Visit: _____

Are you Currently Working? ☐ Yes ☐ No

If "No", How long have you been off work? _____

At the present time I am able to:

☐ Work without restriction
☐ Work the same job with restriction
☐ Work a different job with restrictions
☐ Unable to work because of dysfunction
☐ Homemaker ☐ Part-time ☐ Retired

Is an attorney involved in this case? ☐ Yes ☐ No
Attorney's name and number _____

Have you sought previous treatment for this condition?

☐ No other treatment
☐ Massage Therapy
☐ Physical/Occupational Therapy
☐ Psychiatrist/Psychologist
☐ Chiropractic ☐ Other _____

Please list all the medications that you are currently taking including pills, injections and skin patches _____

Please list any upper extremity surgeries/procedures including the approximate dates and reasons for the surgeries or procedures

Date	Surgery/Procedure	Reason

Please check all the following conditions that apply to you either presently or in the past:

- ☐ High Blood Pressure
- ☐ Arthritis OA RA
- ☐ Dizziness/Fainting
- ☐ Thyroid Problems
- ☐ Emphysema/Bronchitis
- ☐ Chemical or Alcohol Dependency
- ☐ Emotional/Psychological Problems
- ☐ Heart Surgery: Date: _____
- ☐ Other contagious conditions: _____
- ☐ Diabetes
- ☐ Epilepsy/Seizure
- ☐ Kidney Disease
- ☐ Chest Pain
- ☐ Tuberculosis
- ☐ Cancer
- ☐ MRSA
- ☐ Allergies: _____
- ☐ Gout
- ☐ Stroke
- ☐ Hepatitis A B C
- ☐ Heart Attack
- ☐ Depression
- ☐ HIV
- ☐ **PACEMAKER**

Have you experienced any significant changes in:

- ☐ Mood
- ☐ Sleeping Habits
- ☐ Interest or pleasure in daily activities
- ☐ Loss/Gain of appetite or weight
- ☐ Ability to think or concentrate
- ☐ Energy level (restlessness, lethargy or fatigue)
- ☐ Recurrent thoughts of death or of harming yourself

How many packs of cigarettes do you smoke daily? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how many drinks do you consume at one time? _____

Are there any other substances that you use regularly? _____

In what quantity? _____

Are you aware of your current diagnosis? ▼

Do you have any questions about your diagnosis or prognosis? ▼

Rate your average level of discomfort on the scale below:

0 = No Pain 10 = Severe Pain

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

MEDICARE PATIENTS ONLY

HEIGHT: ____ FT. ____ IN.	WEIGHT: ____ LBS.

- FOR OFFICE USE ONLY -

REMEMBER TO CHECK:

PAIN • SMOKING STATUS • ALCOHOL USE • TAOS • MEDICATION

Patient's Signature: _____

Therapist Signature: _____

Form was reviewed with patient: Yes No