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

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? Yes No
Do you have any questions about your diagnosis or prognosis? Yes No
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