



Arm and Hand Rehab 6692 Merchandise Way, Suite C Diamond Springs, CA 95619	Phone (530) 621-1149 Fax (530) 626-3049
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Specialized in Upper Extremity Rehabilitation

Medical History

Have you had Therapy for this problem before? Yes No

If Yes, what type of treatment? _____

What diagnostic tests have been done: X-ray _____ MRI _____ CTscan _____ Bone Scan _____
 EMG/NCV _____ Myelogram _____

Which doctor ordered and reviewed the results? _____ date last seen _____

What medication are you currently taking? _____

How are you managing your pain? _____

Allergies: Cortisone _____ Shellfish or Iodine _____ Other _____

Do you have a history of:

Item	Y	N	Item	Y	N	Item	Y	N
Alzheimer's			Chest pain			Hypoglycemia		
Liver disease			Hypertension			Seizures		
Cancer			Diabetes			Stroke(date _____)		
Tuberculosis			Pacemaker			Anxiety disorder		
Lung disease			Hepatitis			Drug/substance addiction		
Hemophilia			Bruise easily			Psychiatric care		
Arthritis			Hypotension			Circulatory disorders		
Cardiac problems			Skin disorders			Neurological problems		
Fractures			Immune system					

What is your approximate weight? _____ What is your average resting BP? _____

Have you ever had any other illness not noted above? _____

Have you ever had surgery, when and what for? _____

Women Only

Are you currently known to be pregnant or are you trying to become pregnant? YES NO

How many months? _____ Are you currently breast feeding? YES NO

THE ABOVE INFORMATION PROVIDED TO MY THERAPISTS IS TRUE TO THE BEST OF MY KNOWLEDGE. IF UNDER 18 YEARS OF AGE THIS MUST BE SIGNED BY A PARENT OR GUARDIAN AND THEY MUST BE AVAILABLE DURING EVALUATION AND TREATMENT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE TREATING STAFF OF ANY UPDATES ON MY MEDICAL STATUS AND CONVEY CONCERNS THAT I MIGHT HAVE. I WILL INFORM THE STAFF IF I HAVE ANY NEED FOR ACCOMMODATIONS. In order to maintain a safe environment for the staff and the other patients, please call to reschedule if you have signs & symptoms (ie, fever) of cold/flu or other contagious illness.

Patient/Guardian signature _____

date _____



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Reviewed by _____

Pain Questionnaire

1. When did your pain begin? _____ Do you know how your pain began? If so, briefly describe: _____
2. Rate your pain: (none) 0__1__2__3__4__5__6__7__8__9__10 (excruciating pain)
3. Does rest help your pain? Yes___ No___
4. Has your doctor restricted your activity? Please describe: _____
5. Please answer the following questions:
 - a. What is your occupation? _____
 - b. Are you currently working? Yes___ No___
 - c. What was your last day worked? _____
 - d. What percentage of your day do you: Sit? _____ Stand? _____
6. Please check if you have trouble performing any of the following activities:

Dressing	Childcare	Gardening	Housekeeping
Toileting	Cooking	Home/Car repair	Animal Care
Bathing	Laundry	Shopping	Keyboard/Typing
Eating	Walking	Telephone	Driving car
Writing	Property Maintenance	Firewood	Other

7. What activities do you want to return to?

8. What are your leisure activities now?

9. What is your primary goal for therapy?

10. Do you exercise regularly or belong to a gym?

