PALM BEACH | HAND TO SHOULDER

NEW PATIENT INFORMATION

Last Name	First Name	M.I.	Suffix/Title

DOB	Age	Marital Status	Race	Language
		☐Single ☐Married ☐Domestic Partnership ☐Divorced ☐Widowed		☐English ☐Spanish
SS#			Gender	

Occupation (If retired, indicate so and list prior occupation)	Employer

Home Phone	Work Phone	Cell Phone	Email address

Primary Mailing Address (Street Number/Name, Unit/Apt No., City, State, Zip)

Secondary Mailing Address (Street Number/Name, Unit/Apt No., City, State, Zip)

Spouse/Partner Name	If minor, Parent or Legal Guardian Name

Emergency Contact Name	Relationship to Patient

Emergency Contact Phone Number(s)	Emergency Contact Address

Primary Insurance: ☐Health Insurance ☐Cash ☐Auto Accident ☐Workers Comp

Insurance Co.	Policy #	Group #

Primary Insured Name if other than patient (Last, First, MI)	Relationship to Patient	DOB	SS#

Primary Insured Employer	Employer Address

Primary Insured Phone Number(s)	Home	Cell

Secondary Insurance: ☐Health Insurance ☐Cash ☐Auto Accident ☐Workers Comp

Insurance Co.	Policy #	Group #

Primary Insured Name if other than patient (Last, First, MI)	Relationship to Patient	DOB	SS#

Primary Insured Employer	Employer Address

Primary Insured Phone Number(s)	Home	Cell

I certify that the above information is current and accurate to the best of my knowledge.

Patient or Legal Guardian Signature:	Date:

1002 S Old Dixie Hwy Suite 105 Jupiter, FL 33458
T: 561.746.7686 F: 561.746.3420

PALM BEACH | HAND TO SHOULDER

PATIENT INTAKE FORM

Today's Date:

Patient Name:	Age:	DOB:
PCP:	Referred to Dr. Diaz by:	

☐ Right handed ☐ Left handed ☐ Ambidextrous

Occupation (If retired, please indicate so and list prior occupation):

Please list your recreational interests (sports, instruments played, hobbies, etc):

Reason for today's visit:

Date of onset: Was there a specific injury? ☐Yes ☐No

Are your current symptoms work-related? ☐Yes ☐No ☐Somewhat

Are you able to keep performing your job? ☐Yes ☐No ☐Somewhat

If not, are you able to perform modified duty? ☐Yes ☐No

If not, when was the last time you worked?

Are your current symptoms the result of an accident? ☐Yes ☐No

Road traffic accident? ☐Yes ☐No Boating accident? ☐Yes ☐No

Is there litigation pending related to this injury? ☐Yes ☐No ☐Maybe

If yes, please explain. Use back of this form if necessary.

Please describe your symptoms by checking all that apply:

☐Sharp or stabbing	☐Dull or aching	☐Radiating	☐Throbbing
☐Constant	☐Intermittent	☐Activity-related	☐Pain at rest
☐Numbness	☐Weakness	☐Stiffness	☐Feeling of giving way

Do your symptoms wake you up at night? ☐Often ☐Sometimes ☐Never

Please describe how you are limited by your symptoms.

List anything that alleviates or lessens your symptoms (e.g. certain positions, splinting, medication, rest).

List anything that aggravates your symptoms.

If you are having shoulder symptoms, please check all that apply:

☐Pain with overhead motion	☐Pain with reaching around your back
☐Pain with heavy lifting or repetitive activity	☐Pain while bringing your arm across your body
☐Pain while sleeping on your affected side	☐Feelings of instability or giving way
☐Loss of strength	☐Popping, locking, catching, or grinding
☐Associated neck pain	☐Pain, numbness, or tingling that radiate past elbow
☐Stiffness or loss of motion	☐Other

If you are having hand, wrist, or elbow symptoms, please check all that apply:

☐Loss of feeling in fingers: ☐thumb ☐index ☐middle ☐ring ☐little

☐Loss of dexterity or fine motor skills (e.g. buttoning shirt, putting on earrings, handwriting, handling small objects)

☐Stiffness or loss of motion	☐Deformity	☐Swelling
☐Locking, catching, or snapping	☐Pain with heavy or repetitive activity	☐Pain with grip
☐Loss of grip strength	☐Discoloration of fingers	☐Cold intolerance