CONCEPT Occupational & Hand Therapy, Inc.

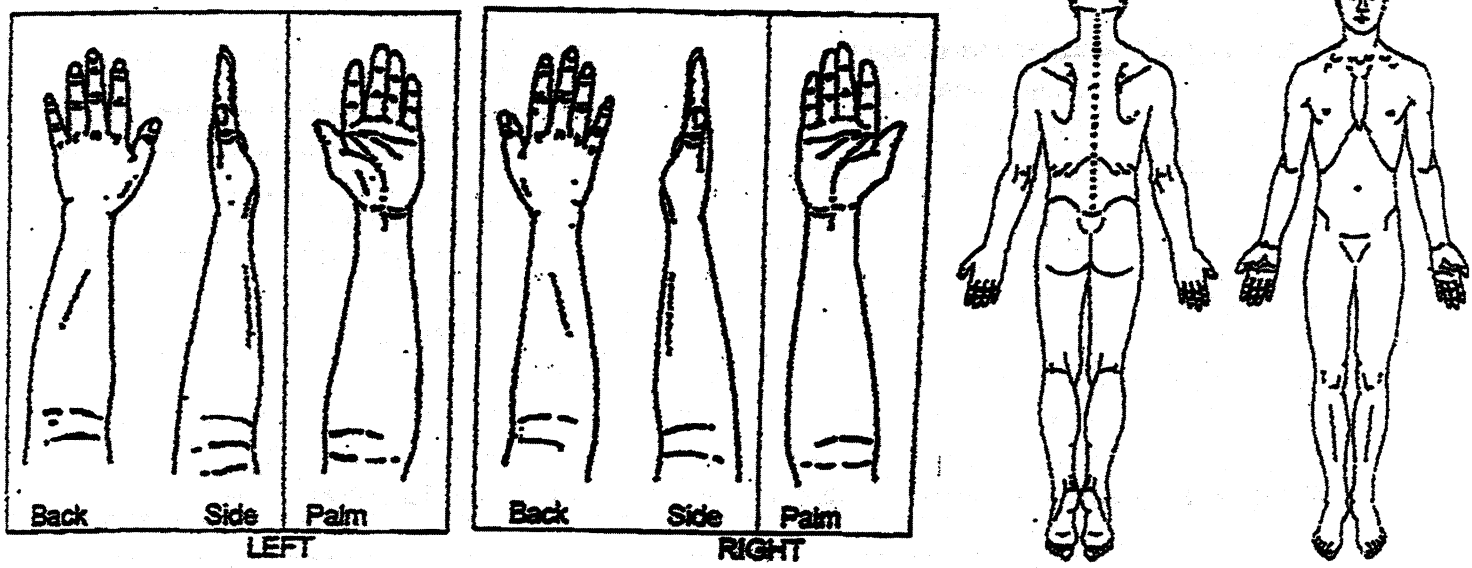
Medical History Questionnaire:

Name _____ Date _____

What problem are you here for today?_____ When did the problem start?_____

Describe how your problem or injury occurred:_____

Indicate (on the figures below) your areas of discomfort:



Please rate your pain on a scale of 0-10. 0 is NO PAIN and 10 is UNBEARABLE PAIN.
Circle the number for the amount of pain you have AT REST and WITH ACTIVITY

AT REST	NO PAIN	0	1	2	3	4	5	6	7	8	9	10 UNBEARABLE PAIN
WITH ACTIVITY	NO PAIN	0	1	2	3	4	5	6	7	8	9	10 UNBEARABLE PAIN

What is the frequency of your pain? ___constant ___4 or more times/day ___1-3 times /day
___4 or more times/week ___1-3 times /week ___No Pain

Does you pain wake you at night? Yes No If yes, how many times per night?_____

What eases your symptoms? Heat Ice Rest Medication Change in position Other_____

Are you able to continue working? Yes, Full duty Light duty No, Last day worked: _____

Are you able to continue your recreational activities? Yes No Limited explain: _____

What specific activities, at home or work, are you unable to perform? _____

Are you able to reach (extending the hand(s) and arm(s) in any direction)? Able Unable Difficult

Are you able to hold, grasp, turn or otherwise work with hand)? Able Unable Difficult

Are you able to pinch, pick, or otherwise work with fingers? Able Unable Difficult

Are you able to feel (perceive size, shape, temperature or texture with your finger tips)? Able Unable Difficult

How is your condition progressing overall? Improving Staying the same Getting worse

(PLEASE COMPLETE OTHER SIDE)

General Health Questions

Have you had a similar problem before? Yes No If Yes, When? _____

Have you had treatment for this problem before? Yes No
If Yes, what treatment? PT OT Chiropractic Massage Orthotics Splint/brace
Injects Pressure Garments X-ray NCT CT scan Other _____

Are you currently taking any medication for this, or any other medical problem? Yes No
if Yes, please give name and dosage: _____

ANY KNOWN ALLERGIES TO MEDICATION? _____

Your age ___ Height ___ Weight ___ Do you exercise regularly? Yes No

Do you smoke? Yes No If yes, How much? _____ How long? _____

Females: Are you pregnant, at this time? Yes No Not applicable

Have you had any long term use of Prednisone, Cortisone, steroids, inhalants Yes No
If Yes, please specify _____

Please circle if you have had any of the following, at any time in your life:

connective tissue disorder Lupus metal implants polio bleeding disorder

cancer lung problem tuberculosis heart disorder high blood pressure blood clots

stroke **arthritis** sprains/strains whiplash broken bones osteoporosis

nerve disorders allergies **asthma** seizures concussion unusual/frequent headaches

hepatitis **diabetes** hypoglycemia phlebitis orthopedic surgeries (bones or joints

surgeries(other) major accident with injuries/fractures allergic to latex **Thyroid problem**

please describe any circled or "other" items _____

What are your goals and expectations for your therapy?

_____

Patient Signature _____ Date: _____