PLAZA
PT, OT, and Hand Therapy

Medical History Information

Name: _____ Date: _____/_____/_____

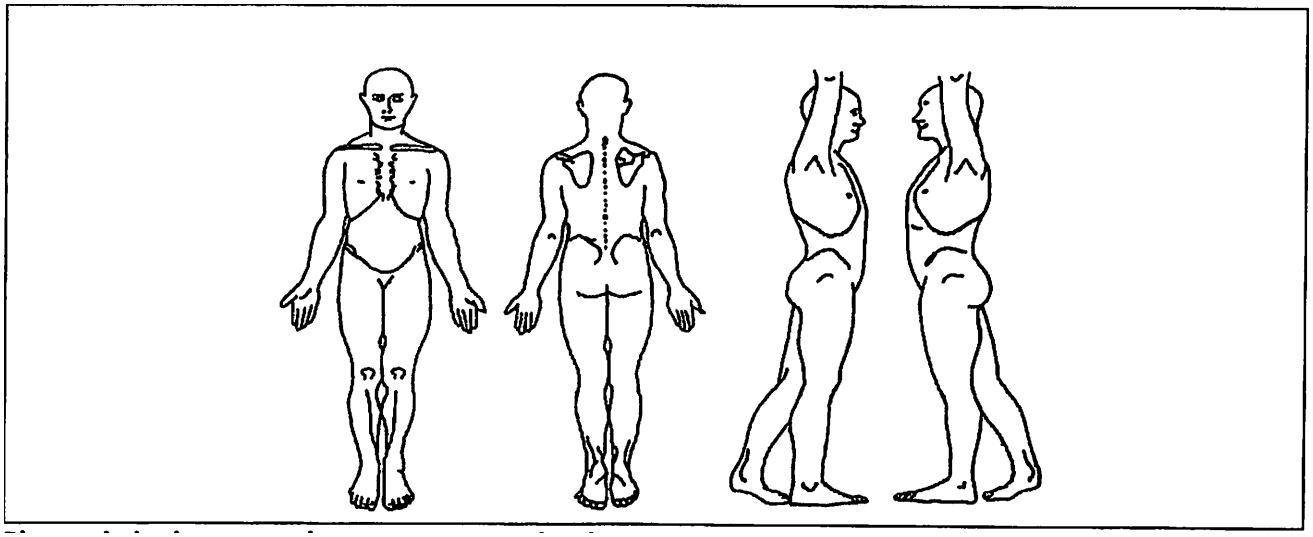
DOB: _____/_____/_____ Age: _____ Hand Dominance: R / L

Height: _____ Weight: _____ Occupation: _____

1. What problem / issue brings you in today? _____
2. What date (roughly) did your symptoms start? _____
3. Have you had surgery for this problem? Yes / No If yes, date/s of surgery? _____
4. How did this issue begin?

   _____

Please circle the areas where you are experiencing your symptoms on the drawing below:



Please describe your pain (circle all that apply)

Dull Achy Burning Stabbing Numbness Tingling Tightness

5. How often does your pain occur? (circle one) Constant Occasionally Frequently
6. What makes your symptoms better? _____
7. What makes your symptoms worse? _____

8. Do your symptoms wake you up at night? Yes / No / Sometimes
9. What treatments have you received so far for this issue?

Massage Injections Chiropractic Occupational Therapy Physical therapy

10. What diagnostic tests have you had for this problem? (circle all that apply)

X-ray MRI CT scan Bone Scan EMG Other: _____

Medical History (check all that apply)

__Diabetes __Cancer __High Blood Pressure __Cardiovascular Conditions

__Osteoarthritis __Osteoporosis __Rheumatoid Arthritis __HIV

__Stroke / TIA __Current Infection __Other: (please explain) _____

_____

Medications

Please list all medications, supplements and over-the-counter drugs you are currently taking:

Medication Name	Dose

11. What are your goals for treatment? _____
12. Do you have any allergies? Yes / No If yes, please list them:

_____

13. Do you use tobacco? Yes / No If yes, please indicate type, amount, and frequency:
14. Are you currently working? Yes / No / N/A
15. Have you missed work due to your condition? Yes / No If yes, how long? _____
16. Have you received any physical / occupational therapy this year? If yes, where and how many visits? _____