Patient Medical History

Shoulder & Hand Therapy Center

Name: ____ Today's date: ________________________

Dominant hand: ☐ Right ☐ Left

Referring doctor's name: ______________________________________Next appointment: ________________

Work Information

Are you currently employed? ☐ Full-time ☐ Part-time ☐ No ☐ Student ☐ Retired Job title: ___________________

What are your job duties/responsibilities? ____

Current work status: ☐ Full-duty ☐ Light-duty ☐ Off-duty ☐ One-handed ☐ With restrictions: _______________

PAST MEDICAL HISTORY:

Please check if you are a ☐ Non-smoker ☐ Smoker

Please circle/list any past or current medical conditions:

Heart disease	High blood pressure	Stroke	Diabetes: 1 or 2; Complications:
Pacemaker/Defibrillator	Irregular heart rate	COPD	Arthritis: Osteo or Rheumatoid
Gout	Neck pain	Back pain	Cancer, type: Year:
Head injury, date:	Other:		

Please list any previous neck, shoulder, arm, or hand injuries and/or surgeries:

____Date: ________________

____Date: ________________

____Date: ________________

Do you have any metal implants or artificial joints? ☐ Yes ☐ No; if yes please list: ____________________________

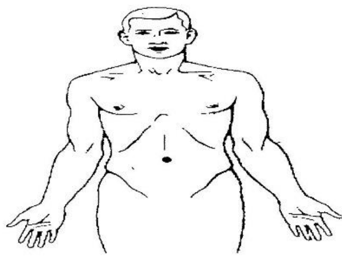
Do you have any allergies? Please specify: ____

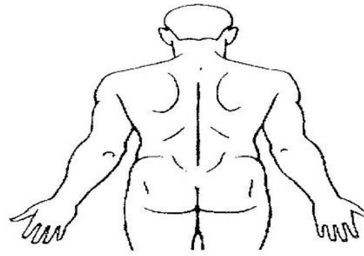
Please list *ALL* Medications, Over-the Counter medicines, Vitamin/Mineral Supplements & Herbal Supplements (even if you only take them occasionally as needed for headache, seasonal allergies, etc.):

Name	Dosage	Frequency	Type (please circle)
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:

Continue on back if needed…

SYMPTOMS: Use this diagram to circle any problem areas
Mark pain as slashes (///) and any numbness/tingling or pins & needles as dots (:::)





1) SYMPTOMS / CHIEF COMPLAINTS: (i.e. stiffness, weakness, pain, numbness, scarring, difficulty with …, etc.)

____

____

When did symptoms start? ______________________ What happened? ____

Date of surgery, if applicable: ____________________________ Are you under any medical restrictions? ☐ Yes ☐ No

If yes, please list: ____

2) Average pain intensity:

At rest: (no pain) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (worst)

Last 24 hours: (no pain) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (worst)

3) Describe your pain: ___________________________ Where does it hurt? __________________________________

What makes it better: __________________________ Worse: ____________________________

4) Do you have numbness/tingling: O No O Yes, location: ____

5) How often do you experience your symptoms?

O Intermittent (<25%) O Occasionally (26-50%) O Frequently (51-75%) O Constantly (>75%)

4) How much have your symptoms interfered with your daily activities? Including personal care, home, and work…

⓪ Not at all ① A little bit ② Moderately ③ Quite a bit ④ Extremely

6) What are your goals for therapy? ____

____

7) In general, would you say your overall health right now is…

O Excellent O Very good O Good O Fair O Poor

- Thank you -