Please complete both sides of this questionnaire for the doctor.

Name: ____ Date: _________________

Age: ____________ Are you Right-handed, Left-handed, or Both (ambidextrous)?

Who referred you to this office? ____

Is this a: Work Injury (Y / N), Motor Vehicle Accident (Y / N), or Liability Injury (Y / N)

Which side is your problem on? Right / Left / Both Sides

What are your symptoms? ____
____

Do you get any numbness or tingling in your fingers? Y / N

When and how did symptoms begin? ____
____

What makes it feel better? ____

What makes it worse? ____

Do you have any limitations from this problem? Y / N Explain: _____________________
____

List any treatment or surgery you've had for this problem: __________________________
____

List any testing, x-rays, or therapy you've had for this problem: ____________________
____

Any prior hand problems? If so, what?____

Hobbies or leisure activities or interests: ____
____

Are you currently working? Y / No If no, when did you stop? ___________________

Employer: ____

Occupation and job description: ____
_______________________________________ How long in this position? ____________

Other employment at time of injury: ____

Comments: ____
____
____

MEDICAL HISTORY AND GENERAL INFORMATION

Name: ____ Date: __________ Pt. #:_____________

Age: ___________ Sex: M / F Height: ____________ Weight: ___________

Dominant Hand: Are you right-handed, left-handed, or ambidextrous (both-handed)?

Medical History: Do you have now or have you ever been treated for? **Please circle Y or N**.

Y / N Diabetes

Y / N Thyroid Problems

Y / N Circulatory / Vascular Problems

Y / N Stroke

Y / N Hypoglycemia

Y / N High Cholesterol

Y / N Hypertension/High Blood Pressure

Y / N Seizure Disorder

Y / N Heart Problems: Irregular Heartbeat / Murmur / Stents / Bypass

Y / N Digestive Problems: Stomach Problems, Ulcers, Reflux, Colitis, Irritable Bowel

Y / N Respiratory or Lung Problems: Asthma, COPD, Tuberculosis

Y / N Arthritis

Y / N Liver Problems: Cirrhosis, Hepatitis

Y / N Kidney Stones or Problems

Y/ N Anxiety / Depression / Bi-polar

Y / N Anemia or Bleeding Disorder

Y / N Cancer: Type ____________________________

Y / N HIV

Y / N Skin Problems

Y / N Eye Problems: Cataracts, Glaucoma

Y / N Sinus Problems

Other illnesses, medical problems, or major injuries, past or present: _______________________

____

Medications allergies? Y / N If yes, which meds: ____________________________________

Any other allergies or sensitivities? Y / N Latex: Y / N Tape: Y / N Metal: Y / N

Other allergies: ____

Current medications and dosage: ____

____

____

List all previous surgeries: ____

____

Smoking status: **Please circle one that best describes your smoking status**

Current every day smoker

Current some days smoker

Former smoker

Never a smoker

Heavy tobacco user

Light tobacco user

Smoker, current status unknown

Unknown if ever smoked

Do you drink alcohol? Y / N How much? ___________

Drug Use? Y / N Do you drink coffee? Y / N

Are you or could you be pregnant? Y / N

Did you receive a flu shot for this flu season (August – March) Y / N

If 65 years old or more, have you ever received the pneumonia vaccination? Y / N

Family Medical History: **Please circle Y or N .**

Y/ N Diabetes

Y / N Heart Problems

Y / N Stroke

Y / N Thyroid Problems

Y / N Hypertension

Y / N Cancer – Type: _______________________________

Y / N Arthritis

Y / N Asthma

Other Pertinent Information: ____

____

Reviewed By: ____ Date: _____________