Medical History and Information

We ask that you complete this medical history form to help provide you with the highest quality of care. Your answers may help guide your treatment plan.

Please circle the answers to the questions below:

Do you have cancer?	yes/ no	Do you ever have seizures?	yes/ no
Are you a cancer survivor?	yes/no	Are you presently pregnant?	yes/ no/NA
Do you have heart disease?	yes/ no	Do you have diabetes?	yes/ no
Do you have a pacemaker?	yes/no	Are you a current tobacco user?	yes/no
Do you have high blood pressure?	yes/ no	Do you have help at home?	yes/no

Other medical conditions we should be aware of:_____

_____

Medications:_____

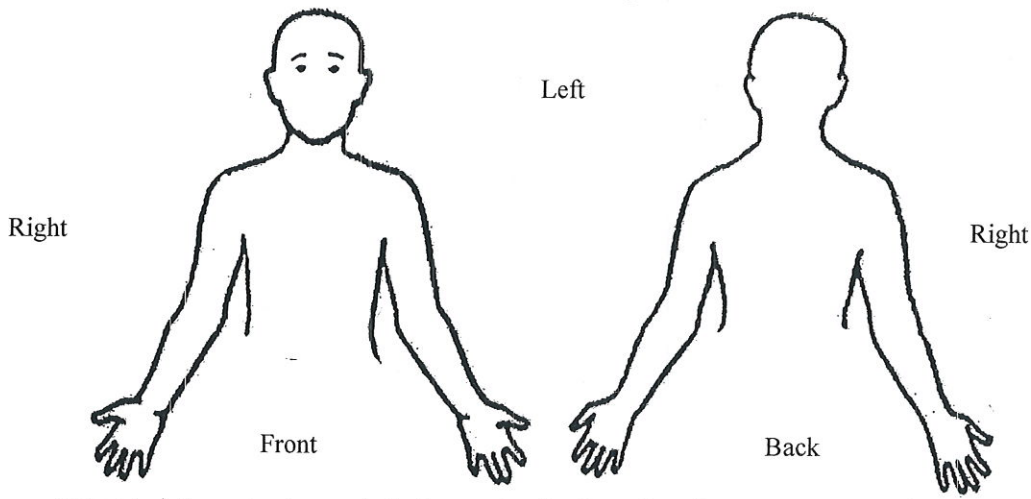
Allergies:_____

Previous injuries affecting neck/arms/hands:_____

Have you had prior therapy for this current condition? **yes/no** If the answer is yes, where?_____

Have you received or are you receiving other rehabilitative therapies this year? This may include physical therapy, occupational therapy, massage, chiropractic or naturopathic care. **yes/no**

If you are experiencing pain, please shade the area/s of pain in the picture below:



Pain intensity scale-please circle the number that best describes your current pain:

No pain Mild pain Moderate pain Severe pain Worst possible pain

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

no pain | can be ignored | interferes with tasks | interferes with concentration | interferes with basic needs | bedrest required

Name:_____Date:_____ Highline and Southwest Hand Therapy 2015