

PATIENT **HISTORY FORM** – *Occupational Therapy* **PLEASE PRINT**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ Most Recent Doctors Appt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem the result of a car accident? Yes\_\_\_\_\_ No\_\_\_\_\_

 Or workplace accident? Yes\_\_\_\_\_ No\_\_\_\_\_

Have you recently had surgery? Yes\_\_\_\_\_ No\_\_\_\_\_

 *If yes, for what?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery Date: \_\_\_\_\_\_\_\_\_\_

**L**

**R**

Have you received **HOME HEALTH**? YES\_\_\_ NO\_\_\_ Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you have experienced any of the following conditions: **Please mark on the drawing where your pain is**

Dropping items\_\_\_\_\_\_\_\_ Gripping/Holding items \_\_\_\_\_\_\_

Carrying items\_\_\_\_\_\_\_\_\_\_ Use assistive devices \_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Pushing/pulling items \_\_\_\_\_\_\_ Weakness of hand/wrist/elbow \_\_\_\_\_\_ Lifting items \_\_\_\_\_\_\_\_ Use of braces/orthotic devices\_\_\_\_\_\_\_Recent fall or trauma \_\_\_\_\_\_\_\_\_ Difficulty coordinating legs/walking\_\_\_\_\_\_\_Are you right or left handed \_\_\_\_\_\_\_\_\_\_ |  |

 ***Please circle one:***

Rate your pain:(1=minimal 10=severe) At its **worst**: 0 1 2 3 4 5 6 7 8 9 10 At its **best**: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain: (please circle) Sharp Shooting Burning Numbness Tingling Ache

Have you had this condition before? Yes\_\_\_\_\_ No\_\_\_\_\_

Have you had any other treatment for this condition? Yes\_\_\_\_\_ No\_\_\_\_\_

 *If Yes, please check:* Chiropractic \_\_\_\_\_ Cat Scan\_\_\_\_\_ EMG/NCV\_\_\_\_ Injections\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_

 MRI\_\_\_\_\_\_\_\_\_ Surgery\_\_\_\_\_\_ X-ray\_\_\_\_\_\_\_\_\_\_ Massage\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following conditions**? *(Please check all that apply)*

 Anxiety/Nervousness\_\_\_\_\_\_ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circulatory Prob.\_\_\_\_\_\_\_\_ Diabetes\_\_\_\_\_\_\_\_\_

 Dizzy Spells\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease/Trouble\_\_\_\_\_\_ High Blood Pressure\_\_\_\_\_ HIV/HEP-C\_\_\_\_\_\_\_\_

 History of steroid use \_\_\_\_ Osteoarthritis\_\_\_\_\_\_\_\_\_\_\_ Pacemaker\_\_\_\_\_\_\_ Rheumatoid Arthritis\_\_\_\_\_\_\_\_

 Skin Disorders/Sensitivity\_\_\_\_ Pregnant\_\_\_\_\_\_\_\_\_ Vision Trouble/Hearing Loss \_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_

**Do you have metal implanted in your body? YES\_\_\_\_\_ NO\_\_\_\_\_** If yes, where*?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all **Prescription MEDICATIONS** you are currently taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had Occupational Therapy? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, indicate at what office and for what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Within this year have you been seen at another Occupational Therapy clinic? Yes\_\_\_\_ No\_\_\_\_ How many visits\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT US? Doctor\_\_\_\_\_ Friend \_\_\_\_ Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Sign up for our Newsletter:*** Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR MEDICAL TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION**

I consent to occupational therapy treatment/provisions of modalities and procedures, as indicated by the therapist and/or physician; which includes Telehealth options. I have reviewed and agree with all office policies including Attendance and Patient Rights and Responsibilities.

**PATIENTS SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

GUARDIAN’S SIGNATURE (if patient is under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_