

Kettering Sports Medicine Center- Medical History (Hand Therapy)

Name: _____ DOB: _____ Email: _____

Date of Injury/Onset _____ Date of Surgery _____ Diagnosis/Problem: _____

Is this a result of a motor vehicle accident? Yes No Result of a work injury? Yes No

Last Day Worked _____ Estimated Date of Return to work _____

At the present time would you describe your health as (circle best): Excellent Very Good Good Fair Poor
Are you presently receiving any other medical or health services? YES NO If yes Describe: _____

Have you had a: test for bone density? YES NO If yes, date _____ Cortisone Injection _____

Family Doctor: _____ List any Doctors you see: _____

Have you been admitted to a hospital or nursing home in the past 30 days? Yes No, If so why? _____

ALLERGIES: Are you allergic to bee stings? YES NO

Describe your pain (circle): Aches Throbs Burns Shoots Sharp Dull Cramps Stabs Radiates Other _____

What makes the pain worse? _____

What makes the pain better? _____

Rate your pain on a scale 0 to 10: 0 = NO Pain 10 = Went to Emergency Room

Pain at least 0 1 2 3 4 5 6 7 8 9 10

Pain at worst 0 1 2 3 4 5 6 7 8 9 10

Current Pain Level 0 1 2 3 4 5 6 7 8 9 10

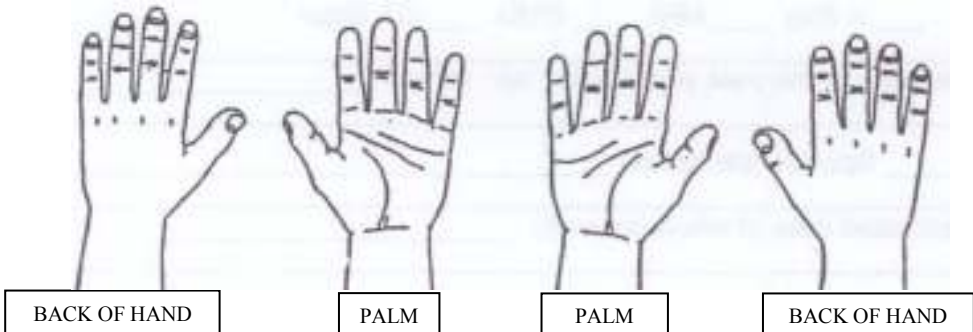
Does the pain interrupt your sleep? YES NO What positions do you sleep in: side: right/left back /stomach Do you sleep in a Bed /Chair

Please mark the diagrams below and indicate where you feel the symptoms

Which Hand is your Dominant Hand (which hand do you write with?): **Right / Left**

LEFT HAND

RIGHT HAND



Do you have numbness / tingling? Yes No, If so, where? _____

What increases it? _____ What decreases it? _____

Do you have limited motion? Yes No Where? _____

Do you have weakness? Yes No Where? _____

Do you have swelling? Yes No Where? _____ When? _____

Have you fallen in the past year? YES NO If yes, how many times: _____ Were you injured from fall(s)? YES NO

Do you live in a (please circle) House Mobile Home Apartment Condominium Other _____

Do you live alone? _____ If no, with whom? _____

Do you have stairs at or in your home? _____ If yes, how many _____ Do the stairs have a railing? _____

Have you recently had any additional stress in your life? If so, please explain: _____

Do you feel unsafe in a current relationship? _____ Have you been a victim of a violent crime? _____

Are there cultural/religious practices that may affect your healthcare? _____ If so, please explain _____

What do you hope to achieve from therapy _____

To the best of my ability, I have given and included all pertinent medical information.

Patient/Guardian Signature **Print Name** **Date**

Reviewed by O.T. and used in determining the Plan of Care **Date**