SETON

Rehabilitation Services

Occupational Therapy/Hand Initial History Information

Date:_____ Email Address: _____

Name:_____ Occupation:_____

Date of Birth:_____ Age:_____

Dominant Hand: Right Left

Referring Physician _____ Primary Physician_____

Clinic where you saw your Referring Physician:_____

Referring Physician's Telephone Number: _____ ( ) Don't know

Do you have a follow up appointment with your doctor? Yes No If yes, when?_____

Goals

What are your goals for therapy? _____

_____

Past Medical History

Please indicate if you have been **diagnosed** with any of these medical problems: ( )No Medical Problems

( ) Seizure Disorder	( ) Stroke	( ) High Blood Pressure
( ) Diabetes	( ) Kidney Problems	( ) Heart Attack
( ) Cancer	( ) Asthma (adult/child)	( ) Tuberculosis
( ) Heart Murmur	( ) Rheumatic Fever	( ) High Cholesterol
( ) Anxiety	( ) Depression	( ) Chest Pain
( ) Arthritis	( ) Childhood Arthritis	( ) Irregular Heartbeat
( ) Cataracts	( ) Glaucoma	( ) Thyroid Disease
( ) Hepatitis	( ) Anemia	( ) Osteoporosis
( ) Rheumatoid Arthritis	( ) Head Injury	( ) Migraines

Other:_____

Do you have any allergies to medicine or latex? Yes No If yes, list here**:**

_____

Do you exercise? Yes No If yes, describe (including how often)_____

Home environment: Do you live alone? Yes No If no, who is with you?_____

Have you fallen in the past 30 days? Yes No

Current Symptoms

Please list your current complaints or problems**:**

_____

How did this problem start (*circle*): Slow Sudden Don't know

Date of injury: _____ Describe how it started: _____

_____

Since this problem started, it is (*circle*): Better No Change Worse

Have you had any recent or past surgeries? Yes No If yes, describe (including date or year):

_____

Have you ever had this problem before? Yes No If yes, how long ago? Did you recover? _____

Please indicate below if you have had any of the following tests (for this problem):

X-Ray CT Scan MRI Date:_____ Facility: _____ Results: _____

Other Tests:_____ Date:_____ Facility: _____ Results: _____

Other Tests:_____ Date:_____ Facility: _____ Results: _____

Circle what time of day it is BETTER: Morning Afternoon Evening Night

Circle what time of day it is WORSE: Morning Afternoon Evening Night

Is this problem interfering with your sleep? Yes No

Does it wake you up at night? Yes No

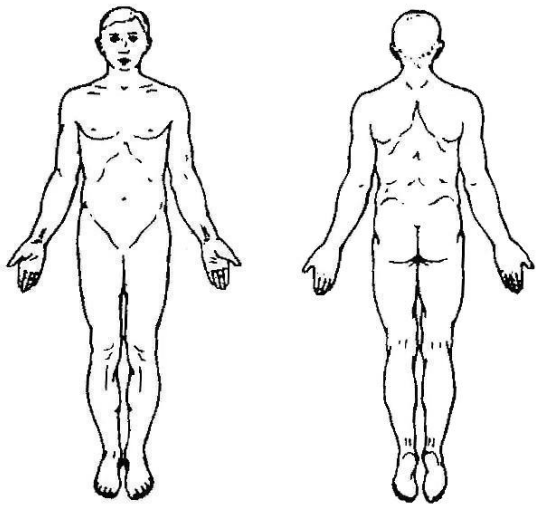
Is your pain (*circle*): Always There Comes and Goes Don't Know

Describe your pain (*circle*): Ache/Sore Sharp Dull Throbbing Tingling Hurt Stabbing

Burning Shooting Pulling Itching Pinching Stinging Rawness

Mild Medium Severe Other:_____

Please indicate on this body map where you are having your problem(s)
(can mark with an X or circle the area)



***AAA* = Dull Ache/Sore BBB = Burning SSS = Sharp, Stabbing TTT = Throbbing ** = Pins & Needles/Numbness**

How much pain you are having today? (*circle*):

No Pain **Take me to the Hospital**

0 1 2 3 4 5 6 7 8 9 10

Circle highest AND lowest amount of pain you've had in the past week?

No Pain **Take me to the Hospital**

0 1 2 3 4 5 6 7 8 9 10

What do you do to make your pain better? _____

_____

Do you have any numbness or loss of sensation? Yes No If yes, where?_____

Please rate how much this problem is affecting the quality of your life (*circle*):

No effect **Worst effect**

0 1 2 3 4 5 6 7 8 9 10

Are you seeing another professional for this problem (chiropractor, massage therapist, etc): Yes No

If yes, please list here:_____

_____ _____ _____ _____

(**patient signature**) **Date** (**therapist signature**) **Date**

Medication

Please list any medications you are currently taking (including vitamins and herbal supplements). The receptionist can make a copy of your medications.

Name of Medication	**Reason for Taking Medication**	**Dosage**	**Number of times a day medication is taken**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____