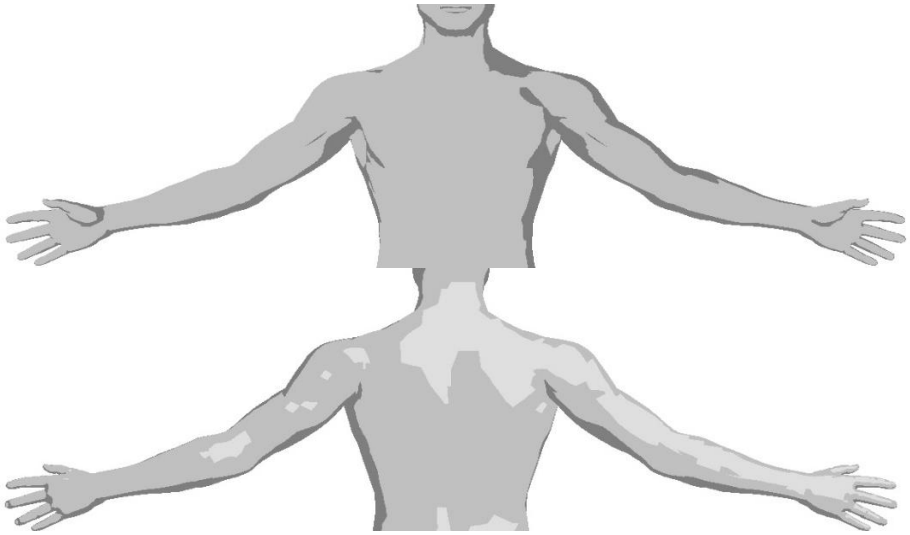
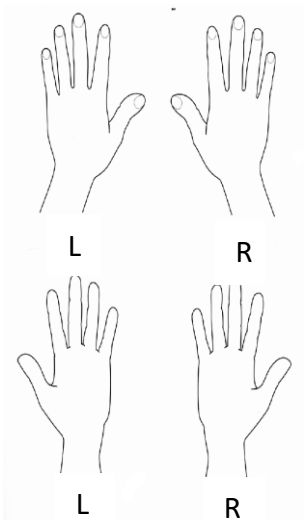
Name:_____
DOB:_____

REASON FOR TODAY'S VISIT

Problem (s) :_____

When did the problem begin? __/___/____ □Injury □Sudden Onset □Gradual Onset
Please Mark the area(s) of pain/ discomfort/ injury: □ Right □ Left □ Bilateral





How did the problem develop? _____
□ Over Use □ Lump/ mass □ Weakness □ Loss of sensation □ Unknown
□ Fall □ Crush □ Cut/Laceration □ Puncture/ Bite □ Twisting Injury □ Burn

Your pain/ discomfort level **Today** is _____ /10 (0= no pain, 10= worst pain)
Your **Worst** pain/ discomfort is _____/ 10

What symptoms do you have? □ Pain □ Numbness/Tingling □ Weakness □ Burning
□ Popping □ Locking □ Aching □ Throbbing □ Swelling □ Skin Changes □ Other:

When is your pain/ discomfort worse? □ With Use □ Morning □ Night □ At All Times
□ Driving □ Lifting □ Gripping □ Pinching □ Other:_____

Does the problem wake you up at night? □ Yes □ No

What helps the problem? □ Rest □ Brace/splint □ Heat/Cold □ Shaking limb □ Other:
□ Medication(s): _____ □ Nothing helps

Who else have you seen for this probem?_____ **When?** _____
What treatment(s) have you had? _____

Prior injuries of the upper extremities: What?_____ **When?** _____

Do you have problems with your: □ Shoulders □ Neck □ Back □ Hips □ Knees □ Feet

Name:_____
DOB:_____

SOCIAL HISTORY

Occupation: _____□ Retired □ Student □ Disabled
□ Currently Working (full / part time) □ Not Working **Last Day Working: ___/ ___/ _____**

What activities do you do at work?_____

Recreational activities/ hobbies?_____ **Frequency?**_____

Do you use tobacco? □ No □Year Quit:___ □ Yes (Smoke/ Chew) Packs/Day:____ Years:___

Alcohol use? □ No □ Yes Drinks/week:_____ **Marijuana use?** □ No □ Yes Frequency:_____

Other Drug use: _____ □Current user □ Former User □ In Recovery

REVIEW OF SYSTEMS: Do you *currently* have or have you ever experienced problems with the following medical conditions:

	No	Current	Past	Family	Explanation
Eye Problems					
Ear, Nose, and throat problems					
Cardiovascular Disease					
Respiratory Disease Asthma, Sleep Apnea -Do you snore? -Has anyone observed you stop breathing while sleeping?	 N N	 Y Y			
Gastrointestinal Problems					
Musculoskeletal disease Arthritis, lupus, Rheumatoid					
Skin Problems					
Brain or nerve disorders					
Bleeding disorders					
Thyroid Problems					
Liver Disease					
Serious Infection HIV, Hepatitis, MRSA, etc					
Psychiatric conditions Depression, etc					
Cancer					
Adverse reaction to Anesthesia					
Other:					

Name:_____
DOB:_____

PAST MEDICAL HISTORY

Please list any past surgeries and the Dates:

●Procedure:_____Year:____ ● Procedure:_____Year:____

●Procedure:_____Year:____ ● Procedure:_____Year:____

●Procedure:_____Year:____ ● Procedure:_____Year:____

Please list any Allergies you have and type of reaction:

●_____ ●_____

●_____ ●_____

Please list all current medications and the dosage:

● Medication: _____ Dose (mg): _____ Times per day: _____
● Medication: _____ Dose (mg): _____ Times per day: _____
● Medication: _____ Dose (mg): _____ Times per day: _____
● Medication: _____ Dose (mg): _____ Times per day: _____
● Medication: _____ Dose (mg): _____ Times per day: _____
● Medication: _____ Dose (mg): _____ Times per day: _____

I am… □ Right Hand Dominant □ Left Hand Dominant □ Ambidextrous

Sign: _____ Date: _____

CURRENT VITALS

[To be completed by office staff:]

Vitals…. Ht:_____ Wt:_____ BP:____/_____ HR:_____ Resp:_____ Temp:_____

Grip Testing: Right:____lbs Left:_____lbs Pinch Testing: Right:____lbs Left:_____ lbs