Hand and Upper Body REHABILITATION CENTER

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# Client Intake Form

Name: ______________________ MALE OR FEMALE Date: ______________________

Address: ______________________ City: ____________ State: ____________Zip: ________

SSN: ______________________ Marital Status: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Date of Birth: ______________________ Hand Dominance: □ Right □ Left □ Ambidextrous

Emergency Contact ______________________ Emergency Contact Phone Number ____________

Referring Physician: ______________________ Family Physician: ______________________

If patient is a minor, who is financially responsible for treatment? ______________________

How did you hear about our services? □ Doctor □ PA/Nurse □ Chiropractor □ Friend/family □ Telephone Book □ Internet □ Other: ______________________

**Are you currently receiving therapy anywhere else?** □ Yes □ No For what problem? ____________
**Are you currently receiving home health services?** □ Yes □ No If yes, where? ____________

**INSURANCE:** Insurance Carrier: ______________________

Policy Holder Name and Address: ______________________

Relationship to Patient: ______________________

ID#:________________Group #: ____________If Worker's Compensation, Claim #:____________

**PAST MEDICAL HISTORY**
Please circle any past or current medical problems you may have:

Cardiovascular Disease
Pacemaker
COPD/Breathing Problems
High Blood Pressure
Cancer: What kind? ______________________

Diabetes I / II
Stroke
Head Injury
Epilepsy/Seizures

Neck or Back Pain
Arthritis: Rheumatoid / Osteoarthritis/ Osteoporosis
Other (please list): ______________________
______________________

Are you taking any medications? Please list: ______________________
______________________

Please check if you are a □ non-smoker □ smoker Are you stressed? □ Yes □ No
Are you pregnant? □ Yes □ No Are you depressed? □ Yes □ No

Please list any previous neck, shoulder, arm, and hand surgeries or injuries:______________________
______________________

Do you have any metal implants or artificial joints? □ Yes □ No Where: ______________________

Do you have any allergies? Please specify: ______________________

Have you had any illness in the past 3 weeks? (cold, flu, bladder or respiratory infection) □ Yes □ No

Have you had a change in your health in the past 3 months? □ Yes □ No

Have you had any of the following tests performed for your current problem?

**X-rays** □ Yes □ No **EMG** □ Yes □ No **CT Scan** □ Yes □ No
**MRI** □ Yes □ No **Nerve Conduction Test** □ Yes □ No

**PLEASE SEE OTHER SIDE**

**WORK INFORMATION**

Are you currently employed? ◻ Yes ◻ No If yes, who is your employer? ___________________________

What is your job title? ___________________________

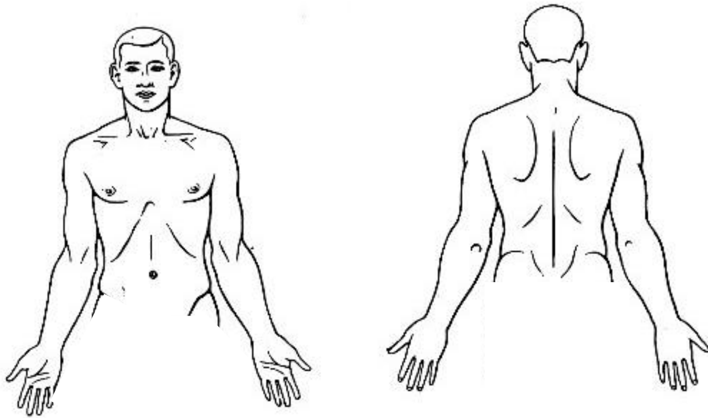
What are your job duties/responsibilities? ___________________________

___________________________

Are you still working despite your injury? ◻ Full-duty ◻ Full-time ◻ Part-time ◻ Restrictions ◻ Retired ◻ Light-duty ◻ One-handed ◻ Off-duty ◻ Disability ◻ Student ◻ Unable to work

**SYMPTOMS**

Please use this diagram to circle any problem areas:



**PAIN**

On a scale of 0 – 10, circle the number that best describes the intensity of your worst pain in the last week.
0 = no pain, to 10 = worst pain you could imagine.

0 1 2 3 4 5 6 7 8 9 10

**TELL US ABOUT YOUR CURRENT CONDITION…**

Date of injury: ____________________ Date of surgery: ____________________

Weight: __________ Height: __________ Age: __________

What happened? Briefly describe your current problem/symptoms: ___________________________

___________________________

Have you ever had these symptoms before? When? ___________________________

Previous treatment for this problem? ___________________________

What makes it better? ___________________________

What makes it worse? ___________________________

Have you tried any braces and/or splints? ___________________________

How does this impact your life? What can't you do as a result? ___________________________

___________________________

What hobbies/recreational activities do you enjoy? Are you having any difficulties performing these activities?

___________________________

What are your goals for therapy? ___________________________

___________________________

**THANK YOU!**

__________
Therapist Initial