Schreiber Upper Extremity Rehab Clinic
Patient History Form

Name: _____

D.O.B.: _____ Age: _____ Sex: _____

Why do you need therapy? _____

Were you injured? _____ Where: _____

Did you have surgery? _____ Where: _____

Injury Date: _____ Surgery Date: _____

Chief Complaint: _____

RATE YOUR INTENSITY OF PAIN (circle one):
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Pain is: dull ache/sharp shooting/stabbing/throbbing/burning/tight/constant/comes and goes

Symptoms began gradually/suddenly on: _____ Where? _____

Has pain or symptoms spread? _____ Where? _____

Do you have numbness of tingling anywhere? _____ Where? _____

Do you have any weakness? _____ Where? _____

Since the onset, pain has increased / decreased / stayed the same _____

What increases your symptoms? _____

What decreases your symptoms? _____

Job Function: _____

Status: Light Duty: _____ Full Duty: _____ Off Work _____

Have you ever been injured on the job? YES / NO Where? _____

How? _____

Please list injuries / accidents: _____

_____

Please list surgeries: _____

_____

Have you had any special Tests? X-Rays, MRI's, EMG's? _____

_____

_____

PAST MEDICAL HISTORY

Check items below if you have or have had any of the conditions below.

Allergies _____	Ear Trouble _____
HIV/Aids _____	Epilepsy _____
Arthritis _____	Depression _____
Broken bones _____	Headaches _____
Bowel/Bladder _____	Jaundice/Liver _____
Cancer/Tumors _____	Spinal Disease _____
Skin problems _____	Stroke _____
Diabetes _____	Polio _____
Respiratory _____	Tuberculosis _____
Swelling hands/feet _____	Varicose Veins _____
Pacemaker _____	Lymphedema _____
Heart Disease _____	Hernia _____
High Blood Pressure _____	Metal Implants _____

Please list any medications that you take: _____

_____

_____

Do you use tobacco? NO_____ YES _____ How much? _____

Alcohol? NO_____ YES _____ How much? _____

Is there anything else that we should know? _____

How did you hear about us? _____ Physician Referral _____

Friend/Family _____ Advertising _____ Newspaper/TV/Radio

Other? _____

I hereby certify that the foregoing statements are true to the best of my knowledge and that I have had no other illness, injury or ailment other than that stated above.

Signature _____ Date: _____

In case of Emergency, who do we need to contact: _____

Relationship: _____ Phone number: _____

_____