Patient Information Sheet

LAST NAME	FIRST NAME	MIDDLE INITIAL

LOCAL MAILING ADDRESS	CITY	STATE ZIP

NORTHERN MAILING ADDRESS	CITY	STATE ZIP

LOCAL HOME PHONE #	CELL PHONE #	SOCIAL SECURITY #	DATE OF BIRTH	SEX: M OR F
				◯ ◯

EMAIL ADDRESS:

Are you presently working? Yes ◯ No ◯

Employer:

Are you RIGHT ◯ or LEFT ◯ handed?

Have you had Home Health Service in the last 90 days? Yes ◯ No ◯

Which area is the problem? Right ☐ Left ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Finger ☐

How did this problem begin? Lifting ◯ Twisting ◯ Falling ◯ Crushing ◯ Motor Vehicle Accident ◯ Unknown ◯

◯ Other:

Was the onset GRADUAL ◯ or SUDDEN ◯ ?

Date of Injury/when problem first occurred:

If you have had this problem for a long time, when did it recently become worse?

DATE OF SURGERY:

Have you had therapy for this condition or any other condition? Yes ◯ No ◯

If "Yes" what body part/when/where:

Have you ever had a fracture or dislocation? Yes ◯ No ◯

If "Yes", which body part/when:

Do you have any of the following metals or plastics in your body?

Rods ◯ Pins ◯ Plates ◯ Staples ◯ Artificial Joints ◯

Metal from gunshot wound ◯ None ◯

Date of Next MD Appointment & Time:

Have you ever been diagnosed as having any of the following?

Yes	No	
◯	◯	Seizures
◯	◯	Cancer
◯	◯	Tuberculosis
◯	◯	Hepatitis
◯	◯	Kidney Disease
◯	◯	Depression
◯	◯	High Blood Pressure
◯	◯	Respiratory Problems
◯	◯	Rheumatoid Arthritis
◯	◯	Other Arthritic Conditions
◯	◯	Chemical Dependency
◯	◯	Diabetes
◯	◯	Do you smoke?
◯	◯	Have a pacemaker?

Please list any allergies:

List any current medications or recent injections:

Signature:_____ Date:_____