Northern Virginia Hand Therapy Center

The Upper Extremity Specialists.

CLIENT INTAKE FORM

Name: _____Date: _____
Hand Dominance: □ Right □ Left Age: _____

How did you hear about our services? □ Doctor □ Physician Assistant □ Friend/family
□ Internet □ Physical Therapist □ Other: _____

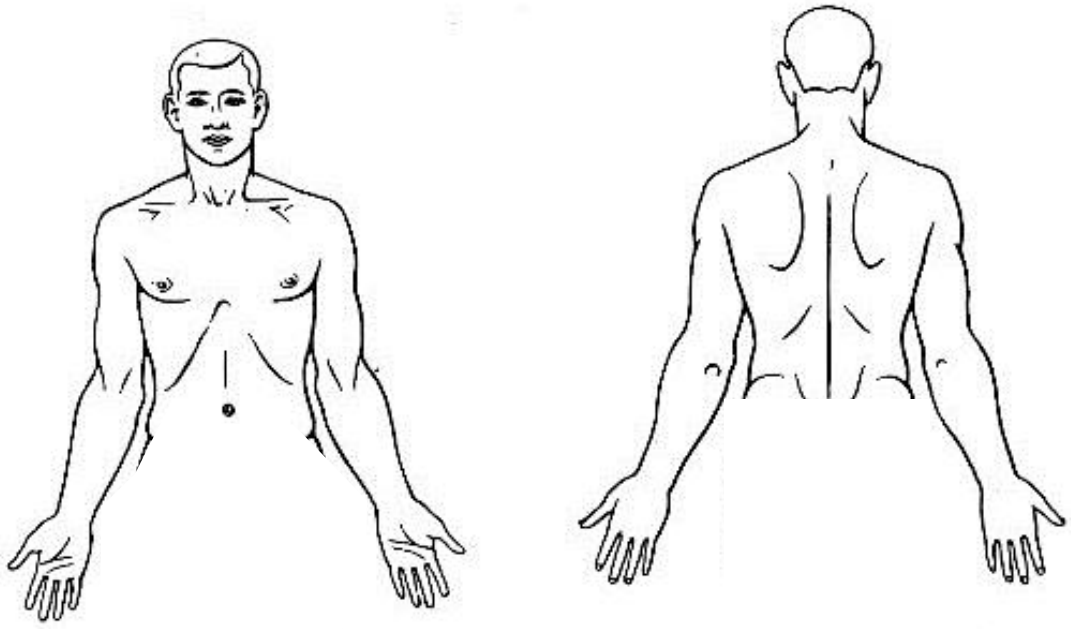
WORK INFORMATION
Are you currently employed? □ Yes □ No
What is your job title? _____
What are your typical work duties _____
_____
What is your work status? □ Full-duty □ Full-time □ Part-time □ Restrictions
□ Retired □ Light-duty □ One-handed □ Off-duty □ Disability □ Student

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

Cardiac Heart Failure Cancer Stroke
Pacemaker High Blood Pressure Head Injury
Cardiovascular Disease Diabetes Neck or Back pain
COPD Gout
Irregular Heart rate Arthritis
Other (please list): _____
Height_____ Weight_____

Please check if you are a □ non-smoker □ smoker
Please list any previous neck, shoulder, arm, and/or hand surgeries and/or injuries:_____
_____
Do you have any allergies? Please specify: _____
Are you taking any medications? Please list:
_____
_____
_____

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: _____

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

_____

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 are your goals in coming to therapy? _____

_____