**New Hampshire Hand Therapy Center, Inc.**
**80 Palomino Lane, Suite 401**
**Bedford, NH 03110**
**603-669-7716/ FAX 603-669-0103**

# MEDICARE PATIENT QUESTIONAIRE

Name: _____ Date: _____ Date of Birth: _____

Chief Problem or Complaint: _____ Date of Injury/Onset: _____

**MEDICAL HISTORY:** Do you currently have or have you ever had:

Yes No High blood pressure?
Yes No Heart problems* (including murmur, abnormal heart rate, etc.)?
Yes No A pacemaker?*
Yes No Angina (chest pain)?*
Yes No A problem with shortness of breath?
Yes No Asthma or allergies?
Yes No Lung problems?
Yes No Recent gain/loss of weight or loss of appetite?
Yes No Any difficulty with bowel or bladder control?
Yes No Thyroid problems?
Yes No Diabetes or low blood sugar?
Yes No Cancer?*
Yes No Osteoporosis?
Yes No Headaches?
Yes No A stroke* or a head injury?
Yes No Any muscular diseases: multiple sclerosis, polio, cerebral palsy or other?
Yes No Fainting spells, seizures or epilepsy?*
Yes No A history of fractures, frequent joint sprains or muscle strains?
Yes No A history of bursitis or tendonitis?
Yes No Arthritis or any unusual joint pain or swelling?
Yes No A history of fibromyalgia, fybromyositis or chronic fatigue syndrome?
Yes No A history of neck or back pain?

(* Can be a contraindication with some treatment modalities)

Yes No Have you fallen in the past 12 months?

**SYMPTOMS:** Do you have or have you ever had:

Yes No Numbness or tingling?
Yes No Weakness in your arms or legs?
Yes No Swelling or temperature changes in your arms or legs?
Yes No Coordination problems?
Yes No A problem with loss of balance?
Yes No Episodes of blurred vision or double vision?
Yes No Do you have impaired hearing?
Yes No Difficulty swallowing?
Yes No Do you wear contact lenses?

***Women Only:***

Yes No Are you or could you possibly be pregnant?

Please list any **allergies** (medication, latex, cream, dyes…) : _____
_____

Please list all **surgeries** and approximate dates: _____
_____
_____

Have you seen anyone else for your current problem? **Y/N** If yes, whom? _____

Please list any other treatments you have received for this injury: _____
_____

**LIFESTYLE:**

Height _____ Current Weight _____ Initial here _____ if you decline to answer.

Do you exercise? No Yes, _____ times per week

Do you use tobacco? No Yes, _____ per day
(This includes all nicotine products such as chewing tobacco, and electronic cigarettes)
If yes, have you ever received counseling to quit smoking within the past 12 months **OR** used over the counter and/or prescribed methods to quit? Please circle one YES NO

**OCCUPATION:** _____

Is this injury work related? Yes No Are you currently working? Yes No
Last date you worked _____

Is this injury motor vehicle accident related? Yes No

What percentage is this injury affecting your life? _____%

Do you have specific goals in mind that you want to reach by the time therapy is completed? **Y/N** If yes, what are they?
_____
_____

**COMMENTS:**
_____
_____
_____
_____

Therapist's Initials _____ Date Reviewed _____

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## PATIENT MEDICATION LIST

Patient's Name: _____

Patient's Date of Birth: _____

| MEDICATION NAME | DOSAGE | FREQUENCY |
|---|---|---|
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**Please Date Below that Medications were Reviewed/Modified and Initial**

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# The CAGE Test for Alcohol Addiction

Name: _____ Date: _____

**I, _____, choose not to participate in this questionnaire.**

**Signature_____ Date _____**

Please, circle YES or NO to each question.

1. Have you ever felt you should Cut down on your drinking?

   YES NO

2. Have you ever been Annoyed when people have commented on your drinking?

   YES NO

3. Have you ever felt Guilty or badly about your drinking?

   YES NO

4. Have you ever had an Eye opener first thing in the morning to steady your nerves or get rid of a hangover?

   YES NO

# Depression Scale

Name: _____ Date: _____

**I, _____, choose not to participate in this questionnaire.**

**Signature_____ Date _____**

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**

2. Have you dropped many of your activities and interests? **YES** / NO

3. Do you feel that your life is empty? **YES** / NO

4. Do you often get bored? **YES** / NO

5. Are you in good spirits most of the time? YES / **NO**

6. Are you afraid that something bad is going to happen to you? **YES** / NO

7. Do you feel happy most of the time? YES / **NO**

8. Do you often feel helpless? **YES** / NO

9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO

10. Do you feel you have more problems with memory than most? **YES** / NO

11. Do you think it is wonderful to be alive now? YES / **NO**

12. Do you feel pretty worthless the way you are now? **YES** / NO

13. Do you feel full of energy? YES / **NO**

14. Do you feel that your situation is hopeless? **YES** / NO

15. Do you think that most people are better off than you are? **YES** / NO

# Elder Abuse Suspicion Index (EASI) Questionnaire

Name: _____ Date: _____

**I, _____, choose not to participate in this questionnaire.**

**Signature _____ Date _____**

Please indicate by circling **ONE** of the answers for each question.

| | | | |
|---|---|---|---|
| 1.Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? | YES | NO | Did Not Answer |
| 2.Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? | YES | NO | Did Not Answer |
| 3.Have you been upset because someone talked to you in a way that made you feel shamed or threatened? | YES | NO | Did Not Answer |
| 4.Has anyone tried to force you to sign papers or to use your money against your will? | YES | NO | Did Not Answer |
| 5.Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | YES | NO | Did Not Answer |

## FOR OFFICE USE ONLY

| | | | |
|---|---|---|---|
| Elder abuse may be associated with findings such as; poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months? | YES | NO | Not Sure |