

New Hampshire Hand Therapy Center, Inc.
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PATIENT QUESTIONNAIRE

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, fibromyositis or chronic fatigue syndrome?
Yes No A history of neck or back pain?

(* Can be a contraindication with some treatment modalities)

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 FILL OUT THE OPPOSITE SIDE OF THIS FORM

Please list all **medications** you are currently taking: _____

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: (circle all that apply)

Are you a smoker? No Yes, _____ per day

Do you drink alcohol? No Yes, _____ glasses per week

Do you exercise? No Yes, _____ per week

OCCUPATION: _____

Is this injury work related? Yes No

Are you currently working? Yes No

Last date you worked _____

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:
