HISTORY AND DETAIL FORM Name _____

PLEASE COMPLETE:

YES **NO** Please check **YES** or **NO** on the appropriate line to answer the following health questions.

☐ ☐ Do you have High Blood Pressure?

☐ ☐ Do you have Diabetes? (Please check one) ☐ Type 1 ☐ Type 2 (Adult onset)

☐ ☐ Do you have any history of Cancer? Type/Area of the body _____

☐ ☐ Do you have Osteoporosis?

☐ ☐ Do you have Osteoarthritis?

☐ ☐ Do you Use any form of Tobacco products? _____

☐ ☐ Are you or could you be Pregnant?

☐ ☐ Do you experience any problems with dizziness?

☐ ☐ Have you fallen in the past year? How many times have you fallen in the past year_____

☐ ☐ Did you sustain any injury when you fell and if so, please explain?_____

☐ ☐ Do you have any communicable diseases, please explain. _____

☐ ☐ Do you have any allergies? If so type _____

Explain the principal cause you are coming for therapy including the location of the issue (Right/Left)

_____

When did your problem start? _____

Is treatment due to surgery? ☐ Yes ☐ No Date of surgery: _____

Have you received Occupational or Physical Therapy anywhere else for this condition? ☐ Yes ☐ No

Hand Dominance ☐ Right ☐ Left

When is your next visit with the referring physician?_____

MEDICATION LIST: Including dosage amounts and times taken per day. You may send a printed list from your pharmacy if desired.

1._____ 2._____ 3._____

4. _____ 5. _____ 6. _____

Is treatment due to an accident? ☐ Yes ☐ No Date of accident:_____

If an accident, is it a Worker's Compensation accident? ☐ Yes ☐ No

If an accident, is it an auto accident? ☐ Yes ☐ No

If Worker's Compensation or Auto please complete the following section:

Name of Employer _____ Adjustor's Name _____

Phone Number _____ Claim Number _____

To the best of my knowledge this description is true, correct and complete.

_____ _____

Patient/Guardian Signature **Date**

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name_____ Date _____

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum/maximum using the last 3 months as your reference. If you have completed this form before, indicate your average pain level since the last time you completed this form.

0 = no pain at all 1-3 = Mild 4-5 = Moderate 6-7 = Severe 7 – 8 Very Severe 9-10 = Worst pain ever

1. **What is your pain RIGHT NOW?**

No Pain ---------- Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

2. **What is your TYPICAL or AVERAGE pain?**

No Pain ---------- Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

3. **What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

No Pain ---------- Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

4. **What percentage of your awake hours is your pain at its best? _____%**

5. **What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

No Pain ---------- Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

6. **What percentage of your awake hours is your pain at its worst? _____%**

DO NOT WRITE BELOW THIS LINE. FOR USE THERAPIST ONLY

Name_____ Age_____ Date_____ Score_____