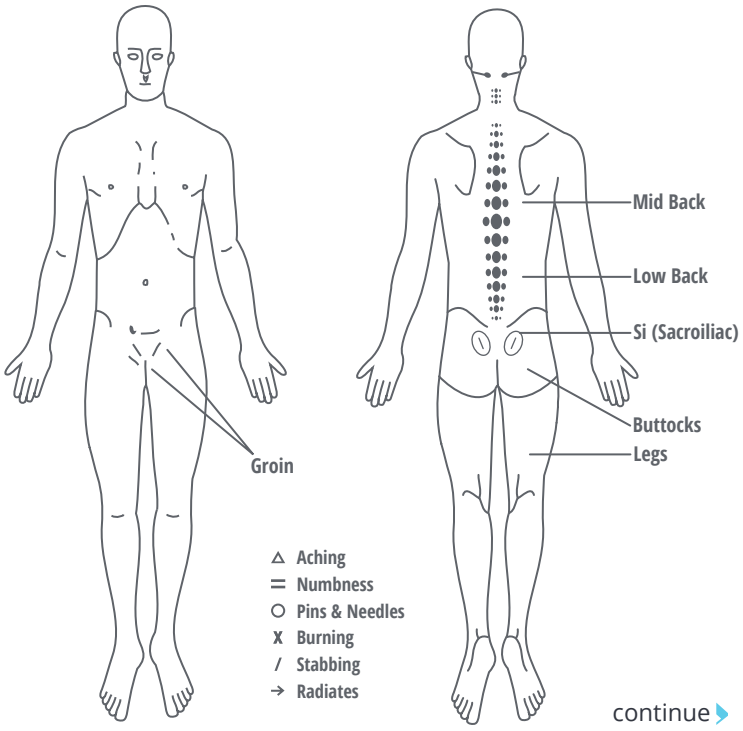
Physical/Hand Therapy
INTAKE FORM

DMOS ORTHOPAEDIC CENTERS

The DMOS PT/Hand Department will strive to create the ultimate orthopedic experience. By providing an extension of our surgeons expertise, we will effectively treat and manage orthopedic issues for the patients and families that we serve.

First name	Last name	Date of birth
Age	Height	Weight
Date of next visit with referring doctor		Primary care physician
Employer	Occupation	
Reason for referral		
Date of injury	Date of surgery	
How symptoms are increased		
How symptoms are decreased		

List previous conditions or surgeries that may contribute to the current issue, then complete the model below for current nature of your pain using the provided symbols.



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Please check if you have you **EVER** been diagnosed as having any of the following conditions**:**

☐ Cancer	☐ High blood pressure	☐ Heart problems	☐ Circulation problems	☐ Blood clots
☐ Bleeding Disorder	☐ Asthma	☐ COPD/Emphysema	☐ Tuberculosis	☐ Stroke
☐ Stomach Ulcers	☐ Thyroid problems	☐ Kidney problems	☐ Hepatitis	☐ Seizures
☐ Multiple sclerosis	☐ Rheumatoid arthritis	☐ Depression	☐ Chemical dependency	☐ Diabetes
☐ Osteoporosis	☐ Osteoarthritis	☐ Other _____		

Please list any medications that you are currently taking: (we can make a copy if you have a list)

_____

_____

Please check any of the following symptoms you are experiencing:

☐ Night pain or night sweats	☐ Blood in urine	☐ Seizures
☐ Tremors fever/chills/sweats	☐ Numbness or tingling	☐ Swelling
☐ Pain/problems blood in stools	☐ Sexual difficulties	☐ Skin rash
☐ Hearing problems	☐ Joint/muscle pain	☐ Eye redness
☐ Easy bruising	☐ Double vision loss of vision	☐ Excessive bleeding
☐ Difficulty breathing	☐ Regular cough arm/leg swelling	☐ Nausea/vomiting
☐ Stress at home or work	☐ Bowel/bladder irregularities	☐ Difficulty swallowing
☐ Heartburn/indigestion	☐ Heart racing in your chest	☐ Post menopause
☐ Urinary incontinence	☐ Dizziness/lightheadedness	☐ Problems sleeping
☐ Weight loss/gain	☐ Pregnant or think you might be	☐ Abdominal pain
☐ Menstrual irregularities	☐ Fatigue	

If you checked any of the above, are you under a physician's care for this/these conditions? ☐ Yes ☐ No

What is your goal for therapy?

_____

_____

_____

Patient signature