Physical Therapy/Hand
INTAKE FORM

DMOS ORTHOPAEDIC CENTERS

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

First Name | Last Name | Date of Birth | Age

Have you been to Physical or Occupational therapy this calendar year? If so, how many visits have you had?

Date of next visit with referring doctor | Primary care physician

Employer | Occupation

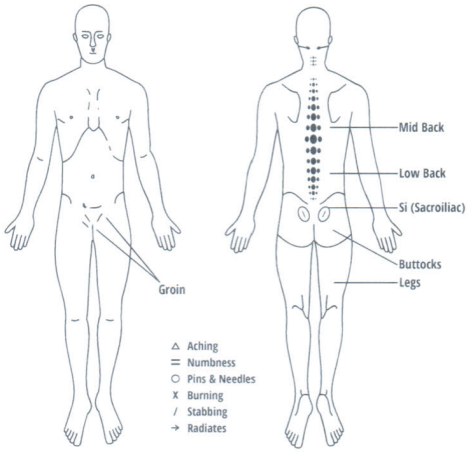
Reason for referral

Date of injury | Date of surgery

How are your symptoms increased?

How are your symptoms decreased?

Complete the model below for the current nature of your pain using the provided symbols.



List previous conditions or surgeries that may contribute to your current issue.

Physical Therapy / Hand

Intake Form

DMOS ORTHOPAEDIC CENTERS

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

□ Asthma	□ Bleeding disorder	□ Blood clots	□ Cancer	□ Chemical dependency
□ Circulation problems	□ COPD/Emphysema	□ Depression	□ Diabetes	□ Heart problems
□ Hepatitis	□ High blood pressure	□ Kidney problems	□ Multiple Sclerosis	□ Osteoarthritis
□ Osteoporosis	□ Rheumatoid Arthritis	□ Seizures	□ Stomach Ulcers	□ Stroke
□ Thyroid problems	□ Tuberculosis	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:

□ Joint/muscle pain	□ Problems sleeping	□ Heart racing in your chest
□ Swelling	□ Fatigue	□ Abdominal pain
□ Numbness or tingling	□ Stress at home or work	□ Nausea/vomiting
□ Arm/leg swelling	□ Seizures	□ Pregnant or think you might be
□ Easy bruising	□ Hearing problems	□ Menstrual irregularities

□ Skin rash	□ Eye redness	□ Post menopausal
□ Excessive bleeding	□ Double vision or loss of vision	□ Sexual difficulties
□ Night pain or night sweats	□ Regular cough	□ Bowel/bladder irregularities
□ Dizziness/lightheadedness	□ Difficulty breathing	□ Urinary incontinence
□ Fever/chills/sweats	□ Difficulty swallowing	□ Blood in urine
□ Weight loss/gain	□ Heartburn/indigestion	□ Pain or blood in the stools

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 Date