PATIENT INFORMATION SHEET

NAME: _____ AGE: _____

DOMINANT HAND: Right / Left

OCCUPATION: _____Last date worked: _____

MEDICAL HISTORY: (List any past or present medical conditions)

_____

_____

ALLERGIES: _____

MEDICATIONS: _____

_____

PREVIOUS ORTHOPAEDIC SURGERIES: _____

_____

LAST DOCTOR VISIT _____ NEXT APPOINTMENT_____

HAVE YOU HAD PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY WITHIN THE CALENDAR YEAR?
Yes / No WHEN: _____

ARE YOU CURRENTLY UNDER HOME HEALTH CARE?
Yes / No

DUE TO MY INJURY I NOW HAVE DIFFICULTY WITH THE FOLLOWING TASKS: (Circle all that apply)

Reaching Overhead	Standing	Walking	Sleeping	Sitting	Lifting
Eating/Drinking	Yard Work	Driving	Bathing	Writing	Stairs
Pushing/Pulling	Housework	Dressing	Computer		

WHEN I FINISH THERAPY I WANT TO BE ABLE TO:

1. _____
2. _____