PROLIANCE SPORTS THERAPY & REHABILITATION

PROLIANCE SURGEONS, INC. P.S.

MEDICAL INTAKE / PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Hand Dominance: ☐ Right ☐ Left Email address: _____

TELL US ABOUT YOUR CURRENT CONDITION…

Date of injury: _____ Date of surgery: _____

What happened? Briefly describe your current problem: _____

_____

Please check all of your symptoms: ☐ pain ☐ stiffness ☐ swelling ☐ weakness ☐ abnormal sensation

☐ other: _____

Previous treatment for this problem? _____

What makes it better? _____

What makes it worse? _____

Have you tried any braces and/or splints? _____

Please check any of the following activities that you are having difficulty with:

☐ Eating / using utensils
☐ Drinking
☐ Bathing / showering
☐ Dressing
☐ Grooming / toileting
☐ Cooking / meal preparation
☐ Opening jars and bottles
☐ Opening medication
☐ Lifting pots and pans
☐ Lifting bags of groceries
☐ House cleaning
☐ Child care
☐ Laundry
☐ Driving
☐ Using keys
☐ Writing
☐ Keyboard / mouse use
☐ Texting / holding phone
☐ Weight-bearing through wrist
☐ Going to the gym
☐ Gardening / yard work
☐ Playing an instrument
☐ Home maintenance
☐ Car repair
☐ Hobbies - specify: _____
☐ Work tasks - specify: _____
☐ Playing sports - specify: _____
☐ Other: _____

PAIN LEVELS

On a scale of 0 – 10, circle the number that best describes the intensity of your worst pain in the last 2-3 days.
0 = no pain to 10 = worst pain you could imagine.

0 1 2 3 4 5 6 7 8 9 10

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

WORK INFORMATION

Are you currently employed? ☐ Yes ☐ No What is your job title? _____

What are your job duties / responsibilities? _____

_____

What is your work status? ☐ Full-duty ☐ Full-time ☐ Part-time ☐ Restrictions ☐ Retired
☐ Light-duty ☐ One-handed ☐ Off-duty ☐ Disability

PLEASE CONTINUE ON THE OTHER SIDE

PAST MEDICAL HISTORY

Please check any past or current medical problems you may have:

☐ Fracture	☐ High Blood Pressure	☐ History of Cancer
☐ Osteoarthritis	☐ Cardiovascular Disease	☐ Obesity
☐ Rheumatoid Arthritis	☐ Alzheimer's	☐ Immunosuppression
☐ Lupus	☐ CVA	☐ Traumatic Brain Injury
☐ Fibromyalgia	☐ Diabetes Type 1	
☐ Current Infection	☐ Diabetes Type 2	

Other (please list): _____

List any previous neck, shoulder, arm, and/or hand surgeries and/or injuries: _____

_____

Height: _____ Weight: _____ Age: _____

Are you a ☐ non-smoker ☐ smoker? Do you have any metal implants or a pacemaker? ☐ Yes ☐ No

Do you have any allergies? Please specify: _____

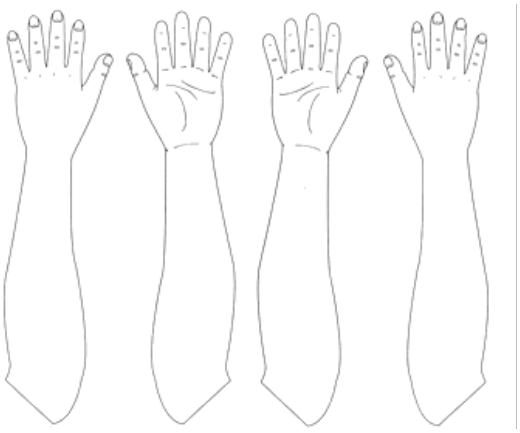
Are you taking any medications? Please list: _____

Have you had any of the following tests performed for your current problem?

Test					
X-rays	☐ Yes	☐ No	CT Scan	☐ Yes	☐ No
Nerve conduction test	☐ Yes	☐ No	MRI	☐ Yes	☐ No
EMG	☐ Yes	☐ No			

SYMPTOMS

Please use this diagram to circle any problem areas:



Left Arm Right Arm

GOALS

What are your goals in coming to therapy? ☐ decrease pain ☐ increase strength ☐ improve motion
☐ improve sensation ☐ decrease swelling ☐ return to work ☐ improve dexterity
☐ learn about joint protection & adaptive equipment ☐ other goals: _____

THANK YOU!

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