Hand Therapy & Occupational Fitness Center
OF SANTA BARBARA

Health History Form

Date_____

Name_____ **Date of Birth**_____

Referring Physician _____

Hand Dominance: ☐ Right ☐ Left ☐ Ambidexterous _____

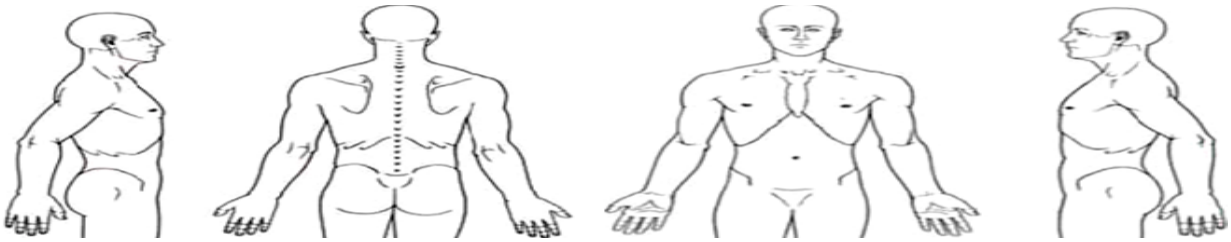
Injured Hand: ☐ Right ☐ Left ☐ Both _____

Reason for Today's Visit_____

Date of Initial Symptoms or Injury_____ **Date(s) of Surgery for Symptoms** _____

Type of Injury: ☐ Home ☐ Work ☐ School ☐ Car Accident ☐ Recreation/Sports ☐ Slip/Fall ☐ Other

Please mark areas of pain:



Numbness or Tingling? ☐ Yes ☐ No Location (if yes): _____

What are your personal goals for recovery? _____

_____

Any goals related to work activity? (for example, time on keyboard, weight needing to be lifted?) _____

_____

Any Exercise/Recreational goals? (when injury free)_____

_____

Medications: (List all **prescription, non-prescription, and supplements**, include doses) or ☐ List Attached ☐ None

Name	Dose	Reason	Route (oral, inhaler, etc)

Name: _____

Allergies: (latex, medications, food, other-list reaction)_____

_____

Pertinent Surgery: (please list type & date)_____

_____

_____

Pertinent Imaging: X-Rays, MRI, CT (Specify by name & results if known)

_____

_____

Sensitive to Heat or Cold?	☐ Yes ☐ No
Sensitive to Tape/Adhesives?	☐ Yes ☐ No
Do you have a pacemaker?	☐ Yes ☐ No
Do you have metal implants?	☐ Yes ☐ No
Females: Are you pregnant?	☐ Yes ☐ No ☐ N/A
History of 2 or more falls in the last year?	☐ Yes ☐ No
Are you a tobacco user/cigarette smoker?	☐ Yes ☐ No
Alcohol Use?	☐ Yes ☐ No If yes, drinks: Per day? ____ Per month? ____ Per Occasion? ____
Height? _____ **Weight?** _____	

Are you actively undergoing cancer treatments at this time? ☐ Yes ☐ No

DO YOU NOW HAVE, OR DO YOU HAVE A HISTORY OF THE FOLLOWING?

Please provide any information that would help us provide better treatment or that emergency services would need to know in the event of any emergency.

Arthritic conditions (OA, RA, etc) ☐ Yes ☐ No
Blood Disorder (Anemia, etc) ☐ Yes ☐ No
Cancer (active, remission, dates) ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Emotional (high stress, depression, anxiety, suicide attempt, addiction, etc) ☐ Yes ☐ No
Gastrointestinal (gallbladder, Crohn's, celiac, gluten sensitivity, etc) ☐ Yes ☐ No
Heart Condition (heart disease/attack, high blood pressure, arrhythmia) ☐ Yes ☐ No
Hormonal (thyroid, etc) ☐ Yes ☐ No
Infection (hepatitis, Lyme disease, Herpes, AIDs) ☐ Yes ☐ No
Headaches/Migraines ☐ Yes ☐ No
Neurological (seizure, MS, Guillain-Barre Syndrome, ALS, stroke) ☐ Yes ☐ No

Skin (cellulitis, psoriasis, hives, rash, etc) ☐ Yes ☐ No
Spine/Orthopedic/Bones: (osteoporosis, fracture, dislocation, neck/back problem, motor vehicle injury, etc) ☐ Yes ☐ No
Women's Health Issues ☐ Yes ☐ No

Other:_____

_____

If you answered yes to any above, please provide further information if necessary:

_____

_____

_____

_____

Signature_____ **Date:**_____

Therapist Signature_____ **Date:**_____