Meridian Hand Therapy

696 Hampshire Road, Suite 180A
Westlake Village, CA 91361
Phone: 805.497.1700 Fax: 805.497.1066

Initial Subjective Report

Name: _____ ***Age:***_____

1. GENDER: Male/ Female HAND DOMINANCE: Left/ Right/ Both (circle one)

2. Please mark diagnoses/conditions you have had (with dates), or currently have:

□ Hepatitis	_____	□ Diabetes	_____	□ Seizures	_____
□ High blood pressure	_____	□ Cancer	_____	□ Immune deficiency	_____
□ Heart disorder	_____	□ Arthritis	_____	□ Dizzy spells	_____
□ Circulation disorder	_____	□ Osteoporosis	_____	□ Other	_____

3. Please list SURGERIES/ recent DIAGNOSTIC STUDIES (MRI, X-rays) you have undergone (procedure and date): _____

4. Do you have METAL (pins, plates, pacemaker) anywhere in your body? (other than your teeth).
NO YES Please indicate where: _____

5. For women: Are you currently PREGNANT? NO YES Months of Pregnancy_____

6. Please list any known ALLERGIES: _____

7. Have you recently taken STEROIDS or ANTI-COAGULANTS for an extended period of time?
NO YES_____

8. Have you had physical therapy treatments before? If yes please indicate where, when and for which problem:_____

9. Briefly describe the history of your present ACCIDENT, INJURY OR ILLNESS:
Onset date:_____ Description:_____

10. Please indicate where your pain is located and circle the range of pain you are experiencing for each body area: (**0** equaling no pain and **10** being equivalent to pain requiring hospitalization).
1. _____ **0 1 2 3 4 5 6 7 8 9 10** 2. _____ **0 1 2 3 4 5 6 7 8 9 10**

11. Is there ever a period without pain? YES NO **(please circle NO only if pain is constant, occurring without movement and during sleep)**

12. How would you best describe your pain? Dull_____ Aching_____ Stabbing____
Grabbing_____ Burning_____ Radiating_____ Other_____

13. Please indicate when your pain is greatest: First thing in the morning____ During the day_____
At the end of the day_____ During sleep_____ Constant _____

14. What other symptoms are you experiencing? Stiffness__ Weakness__ Numbness__ Other___

15. Are you medicating for pain, swelling or muscle spasms? YES NO Medications:_____

16. What aggravates your symptoms? _____

17. What eases your symptoms? _____ (medications, positions, etc..)

18. What activities are you limited in or unable to perform? _____
_____

Patient's Signature_____ Date: _____