



The Hand & Physical Therapy Center Of Marin  
A Physical Therapy Professional Corporation

Date	
Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	City State ZIP
Home Phone	Work/Cell Phone
Social Security Number	Date of Birth

Dominant Hand  Right  Left

Physician Referred By

**Diagnosis**

Date of Injury Date of Surgery

How injured

Employer Occupation

Employer Address City State ZIP

How long at job prior to injury? Are you working now?  Yes  No. Date off work

Previous injuries to this same extremity?  No  Yes. If yes, please explain

Current Medication

Hobbies/Interests

Please check all items as they pertain to your medical history.

Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implants	<input type="checkbox"/> Yes	<input type="checkbox"/>
Dermatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/>
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/>
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Smoker	<input type="checkbox"/> Yes	<input type="checkbox"/>
Immune System Deficiencies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/>

Please explain all yes answers.

**In Case of Emergency**

Name Relationship

Phone Number

I authorize The Hand & Physical Therapy Center of Marin to use and disclose information about my medical diagnosis and the purpose of treatment, payment and health care operations.

Signature

Eval Therapist | Appointment Date | Appointment Time