The Hand & Physical Therapy Center Of Marin

A Physical Therapy Professional Corporation

	Date		
Name			
	. Male	. 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		Yes		No	Implants		Yes	
Dermatitis		Yes		No	Nervous Disorders		Yes	
Diabetes		Yes		No	Numbness		Yes	
Headaches		Yes		No	Pacemaker		Yes	
Heart Attack		Yes		No	Pregnant		Yes	
Heart Disease		Yes		No	Previous Surgery		Yes	
Hernia		Yes		No	Seizures		Yes	
High Blood Pressure		Yes		No	Smoker		Yes	
Immune System Deficiencies		Yes		No	Other _____		Yes	

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 Tiime