



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

Name		Date	
Address		City	State
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