



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

Date:		female <input type="checkbox"/>	male <input type="checkbox"/>												
Patient Name:															
Address								City:		State:		Zip code			
Home phone:				Cell phone:				Work phone:				E-mail:			
Social Security number:					Date of Birth			Marital status:			Dominant hand <input type="checkbox"/>		Right <input type="checkbox"/>	Left <input type="checkbox"/>	
Referring MD:								How did you hear about us?							
Diagnosis															
Date of injury:				Date of Surgery:				Previous surgeries:							
How were you injured?															
Employer:					Occupation:					Address:					
How long at job prior to injury?					Are you working now?					If no, date off work:					
Previous injuries to this same extremity?					If yes, please explain:										
Allergies	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Depression	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Mutiple Sclerosis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Anemia	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Diabetes	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	**Numbness	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Anxiety	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Dizzy Spells	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Osteoporosis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Arthritis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Emphyse/Bronchitis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Parkinson	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Asthma	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Fractures	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Seizures	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Cancer	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Gallbladder issues	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	**Smoker	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Heart-Cardiac conditions	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Hepatitis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Speech Problem	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Cardiac Pacemaker	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	High Blood Pressure	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Strokes	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Chemical Depend.	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Incontinence	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Thyroid disease	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Circulation Problems	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Kidney Problem	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Tuberculosis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Currently Pregnant	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Implants	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Vision Problems	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Describe any other conditions or precautions:															
Injury as a result of a fall in the past year?							Two or more falls in the last year?								
Current Medications, dosage and reason for taking:									In case of emergency: name, relationship, phone number						
Use separate Medication list if necessary-or bring meds to your Evaluation															