SPORTS/Hand Therapy– patient information

Date:_____ Patient's name:_____ Date of birth:_____

During the first visit, we will discuss your answers on this form. This helps us decide what tests/procedures we need to do. Your comments are very important. *Please answer all questions.* *If not applicable to your child, please write: N/A.*

Reason for this visit: _____

What do you hope to accomplish with your therapist? _____

Is the patient having pain? If yes, where and how is it being managed?_____

_____

Customs, religious beliefs or wishes that we need to be made aware of to better serve you: _____

_____

We will be providing you with information to be done at home. Do you have a prefer way of learning new information?

☐ Pictures ☐ Writing ☐ Demonstration ☐ No Preference

Medical history/information:

Allergies: _____

Primary doctor: _____Next Appointment:_____

Other doctors (specialists): _____

Medications:_____

Medical condition(s):_____

Known precautions (non-weight bearing, no sports, etc): _____

Hospitalizations and/or surgeries (with approximate dates): _____

_____

X-Rays, CT scans, or MRI for this condition? ☐ Yes ☐ No Results? _____

Immunizations current? ☐ Yes ☐ No

Please list equipment,braces,or orthotics used: _____

Hand preference to write, eat, etc.: ☐ Right ☐ Left

Previous injuries or therapy for current conditions or for other conditions? _____

_____

What community based physical activities and/or sports are the patient involved in? How long are the sessions and how many times a week do they participate? _____

Along with your child's physical health, we would like to know about your child's mental health.

Are there any family issues that might impact your child's care? ☐ Yes ☐ No

If so, please share:_____

Have you seen any changes in your child's moods or behavior? ☐ Yes ☐ No

If so, please share:_____

Please list any other concerns that you would like us to know:_____

_____

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Thank you for your time in filling out the form so that we may better serve you.