AUSTIN HAND GROUP

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PATIENT INFORMATION: Today's Date: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____ Home Phone: _____

Date Of Birth: _____ Sex: ○ Male ○ Female

Marital Status: ○ Single ○ Married ○ Legally Separated ○ Divorced ○ Widowed ○ Partner

Employment: ○ Student ○ Employed ○ Not Employed ○ Self Employed ○ Retired ○ Active Military

Preferred Language: _____ Race/Ethnicity: _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

REASON FOR TREATMENT:

Condition Related to:

○ None (No trauma/unknown cause)
○ Accident: Date of Accident: _____
○ Motor Vehicle Accident: Date of Accident: _____
○ Employment: Workers Comp Claim# _____ Date of Injury: _____
Employer: _____ SSN: _____

INSURANCE:

Primary Carrier: _____ ID# _____ Group# _____

Secondary Carrier: _____ ID# _____ Group# _____

PRIMARY CARE PHYSICIAN: ○ No Primary Care Physician

Name: _____ Phone: _____

PREFERRED PHARMACY:

Pharmacy: _____ Phone: _____ Cross Streets: _____

HOW DID YOU HEAR ABOUT AUSTIN HAND GROUP?

○ **Physician Referral:**
Name: _____ Facility: _____ Phone: _____
○ **Internet:** Search Engine: ○ Google ○ Yahoo ○ Bing ○ Other: _____
○ **Other:** ○ Previous Patient ○ Insurance Carrier

Patient Name: _____ **Date:** _____

Hand Dominance: ○Right-Handed ○Left-Handed

REASON FOR VISIT/ CHIEF COMPLAINT: _____

Affected Extremity: ○ Right ○ Left ○Both

Date of injury or onset of symptoms: _____

How injury/symptoms occurred: _____

○No known cause/ no trauma.

SEVERITY OF PAIN:

No pain		Mild			Moderate			Severe		Unbearable
0	1	2	3	4	5	6	7	8	9	10

PAIN IS:

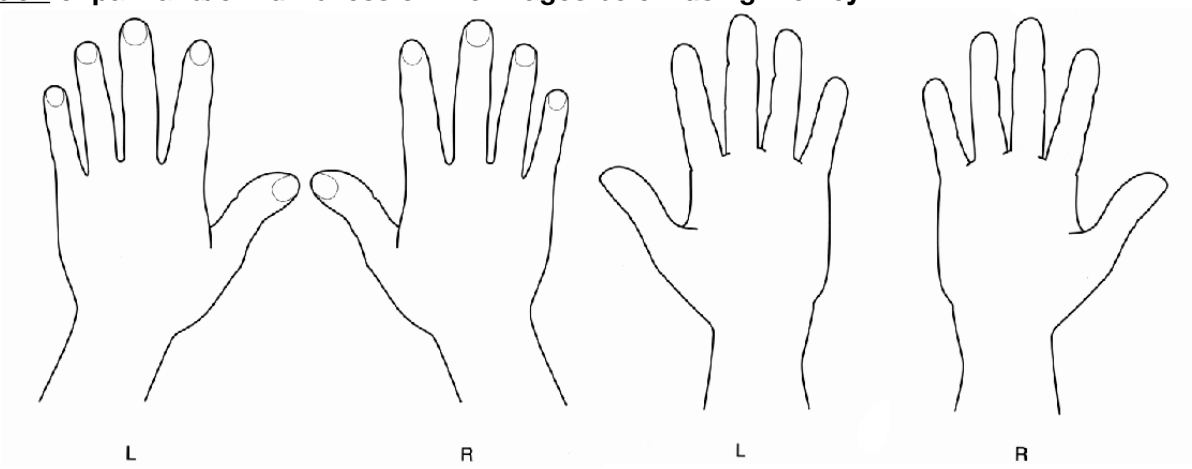
○ Constant ○ Off/On ○ Improving ○ Same ○ Worse ○ N/A

NUMBNESS/ TINGLING IS:

○ Constant ○ Off/On ○ Improving ○ Same ○ Worse ○ N/A

Please indicate the *location* of pain and/or numbness on the images below using the key.

KEY	
XXXX	Burning
////////	Stabbing
+++++	Aching
00000	Pins/ Needles
=====	Numbness



Other/ Additional Comments: _____

Symptom(s) Occur:
○at rest ○during the day ○in the morning ○at night
○while sleeping ○with direct pressure ○with pushups ○with typing
○with grip ○with writing ○with motion ○with twisting motion

Exacerbated:
○by work ○by driving ○by typing
○with writing ○with activity ○with grooming
○with lifting ○with motion ○with reading

Relieved:
○with rest ○with anti-inflammatories ○with splint ○with stopping activity

Associated symptoms:
○activity pain ○post activity pain ○dropping things
○locking ○loss of motion ○morning stiffness
○numbness ○swelling ○weakness

PREVIOUS TREATMENT(S) FOR CURRENT ISSUE:

Performed by:	○*ER/Urgent Care*	○*Primary Care*	○*Other Specialist*	○*Self-treated*
○X-rays	○Bandage/Dressing	○Rest	○Tetanus Shot	○Oral Steroids
○CT Scan	○Buddy Taping	○Hand Therapy	○Pain Medication	○Other:_____
○MRI	○Casting	○Sutures	○Anti-Inflammatories	_____
○EMG/NCS	○Splinting	○Antibiotics	○Steroid injection	

Patient Name: _____ **Date:** _____

PAST MEDICAL HISTORY:

- ○ **NO SIGNIFICANT PAST MEDICAL HISTORY**

○ Asthma	○ Arthritis	○ Alcoholism	○ Anxiety
○ Bleeding Disorder	○ Diabetes	○ Depression	○ Digestive Problems
○ Emphysema	○ Fainting Spells	○ Gout	○ High Blood Pressure
○ Hepatitis A	○ Hepatitis B	○ Hepatitis C	○ Lupus
○ Lung Problems	○ Migraine	○ Kidney Problems	○ Thyroid Problems
○ Tuberculosis	○ Stroke	○ Seizure Disorder	○ Skin Disorder

- ○ Cancer (Please Specify): _____
- ○ Other: _____
- ○ Heart Attack/Trouble: _____
- ○ Cardiologist: _____

PAST SURGICAL HISTORY:

- ○ **NO PAST SURGICAL HISTORY**

○ Left Carpal Tunnel	○ Breast Lumpectomy	○ Mastectomy
○ Right Carpal Tunnel	○ Bunionectomy	○ Ovary Removal
○ Bilateral Carpal Tunnel	○ C-Section	○ Uterus Repair
○ Left Cubital Tunnel	○ Cardiac Surgery	○ Prostatectomy
○ Right Cubital Tunnel	○ Cardiac Stent Placement	○ Rhinoplasty
○ Hand Surgery	○ Cataract Surgery	○ Shoulder Surgery
○ Wrist Surgery	○ Gallbladder Excision	○ Thyroidectomy
○ Abdominal Surgery	○ Colon Resection	○ Thyroidectomy (Partial)
○ Ankle Surgery	○ Laparotomy	○ Tonsillectomy
○ Back Surgery	○ Face Lift	○ Tubal Ligation
○ Bladder Surgery	○ Hemorrhoids	○ TURP
○ Breast Biopsy	○ Hernia Repair	○ Vasectomy
○ Breast Augmentation	○ Hysterectomy	○ Wisdom Tooth Extraction
○ Breast Reduction	○ Knee Surgery	○ Appendectomy

- ○ Other: _____

FAMILY MEDICAL HISTORY:

○ **NO SIGNIFICANT FAMILY HISTORY** ○ **UNKNOWN FAMILY HISTORY**

○ Arthritis ○ Cancer ○ Diabetes ○ High Blood Pressure ○ Heart Disease ○ Lung Disease

SOCIAL HISTORY:

Alcohol Consumption: ○ None ○ Rarely ○ Moderately ○ Daily ○ Socially

Tobacco Use: ○ None ○ Socially ○ 1/2 Pack/Day ○ 1 Pack/Day ○ Past Tobacco Use

Recreational Drug Use: ○ None ○ Rarely ○ Moderately ○ Daily ○ Socially

Occupation: _____

REVIEW OF SYMPTOMS: (Please mark all that apply at TODAY'S vist):

○ Fever/Chills	○ Weight Loss	○ Weight Gain	○ Nausea	○ Diarrhea
○ Hearing Loss	○ Blurred Vision	○ Nose Bleed	○ Vomiting	○ Skin Rash
○ Hoarseness	○ Chest Pain	○ Shortness of Breath	○ Indigestion	○ Muscle Pain
○ Trouble Sleeping	○ Trouble Breathing	○ Persistent Cough	○ Incontinence	○ Easy Bleeding
○ Loss of Appetite	○ Constipation	○ Itching	○ Arthritis	○ Anxiety
○ Loss of Sensation	○ Depression	○ Headache	○ Stiffness	

FEMALE PATIENTS: ○ Pregnant ○ Trying to get Pregnant ○ Breastfeeding

ADDITIONAL COMMENTS:

_____

Patient Name: _____ **Date:** _____

ALLERGIES:

○ **NO KNOWN DRUG ALLERGIES**

Latex Allergy: ○ Yes ○ No

Tape Allergy: ○ Yes ○ No

Medication Allergies: _____

_____

CURRENT MEDICATIONS: ○ **NO DAILY MEDICATIONS**

Medication Name	**Dosage**	**Frequency**	**Route of Administration**

ADDITIONAL COMMENTS:

_____

_____

CONSENT FOR TREATMENT:

I give my written consent for medical and surgical care, evaluations, and tests determined by the providers of Austin Hand Group.

Patient Signature: _____ Date: _____

Patient Name (Print): _____