Beth Israel Lahey Health
Winchester Hospital

Patient Medical Record Number: _____
Patient Name: _____
Patient Email: _____
I am a new patient: yes no
I am a returning patient: yes no
I have had physical therapy this year: yes no

Occupational Hand Therapy

Primary Care Physician: _____Referring Physician: _____

What brings you in today?
Is this visit related to an auto accident? Yes No
Is this visit related to a work injury? Yes No
Have you had any Physical or Occupational Therapy this year? Yes No If yes, why? _____

Hand dominance: Right Left Ambidextrous

History of present illness/condition:

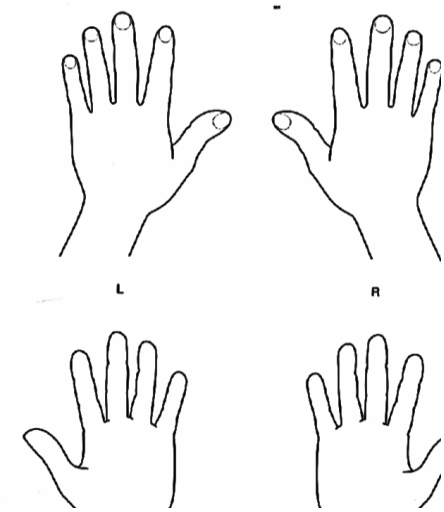
How and when (date) did the present condition occur? _____

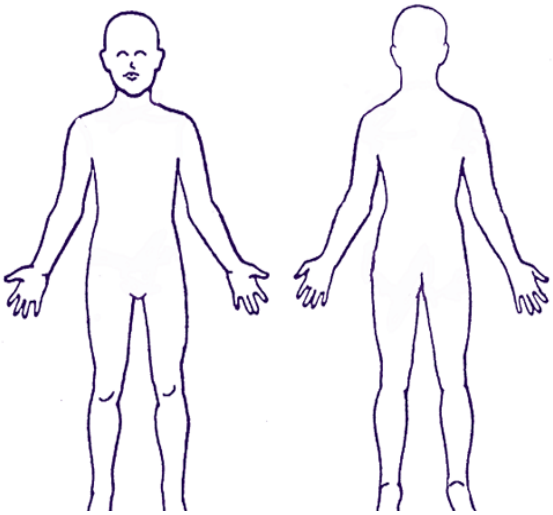
Which extremity is affected? Right Left Both

Did you undergo surgery for this specific condition? Yes No If yes, date of surgery_____

Have you been hospitalized due to this specific condition? Yes No If yes, when and where? _____

Please place an x or circle where the pain/condition is located on the image/images below:





On a scale of 0-10 (10 being excruciating), please rate your pain today 0 1 2 3 4 5 6 7 8 9 10

Does your pain vary? Yes No

Do you have numbness or tingling? Yes No

What activities make your pain worse? _____

What relieves your pain? _____

Can you get comfortable at night? Yes No

What are your functional problems due to this condition? Check all that apply:

___ Opening jars/bottles
___ Picking up/ holding a mug/cup
___ Turning a key in a lock
___ Recreational activities
___ Carrying objects of weight
___ Tying shoes
___ Dressing/buttoning/zipping
___ Eating with utensils/meal prep
___ Vacuuming/ sweeping
___ Brushing teeth/hair

Medical History

Is there any other information regarding your medical history that we should know about (i.e. Diabetes, Osteoarthritis, Cancer)?

Current Medications: (If you receive care at a Winchester, Lahey, or Beth Israel Provider location your medications should be in our electronic medical record system)

☐ Not currently taking any medications
☐ Prescription
☐ Non Prescription/Over the Counter/Vitamin/Mineral/Dietary Supplements/Herbal/Other

Patient Signature: _____Date: _____

Guardian/Representative Signature: _____Date: _____