Pinnacle Hand Therapy Today's Date:

Name: Date of Birth:

Injury / Diagnosis:

Treatment Side: ◯ Left ◯ Right ◯ Bilateral

Injury/Onset Date/Change of Status Date:

Surgery related to today's' visit: ◯No ◯Yes Date of Surgery:

Type of Surgery:

Hospitalization: related to today's visit: ◯ No ◯ Yes
Date of Hospitalization:

Describe your condition and your primary complaint:

Prior Level of Function: (Check any area of difficulty you had BEFORE this diagnosis)
Baseline Functional Level Included all of the Following:
◯ Self Care ◯ Mobility: Walking & Moving Around
◯ Changing & Maintaining Body Position ◯ Carrying, Moving & Handling Objects
◯ Other

Current Functional Limitations: (Check any area you have difficulty *AFTER* this diagnosis)
Please select ALL applicable function al limitations:
◯ Self Care ◯ Mobility: Walking & Moving Around
◯ Changing & Maintaining Body Position ◯ Carrying, Moving & Handling Objects
◯ Other

Medical History
Previous History of Similar Symptoms: ◯ No ◯ Yes
General Health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Social History *Check all that apply*
◯Lives at Assisted Living Facility ◯Lives with Family ◯ Lives with Caregiver
◯Married ◯Single ◯Divorced ◯Widowed

Occupation:

Work Status
◯Full Time ◯Part Time ◯ Light Duty ◯Transitional Duty ◯Out of Work ◯Retired ◯Not Working
◯Homemaker ◯Custom

Duty Level
◯ Sedentary ◯ Light ◯ Medium ◯ Heavy ◯ Very Heavy

Date out of work: ◯ N/A

Date return to work:

Workers Compensation : ◯ N/A ◯ No ◯ Yes

Litigation: ◯ N/A ◯ No ◯ Yes

Home Layout: *Select all that apply*
◯ 1-Story ◯ 2-Story ◯ Condo/Apt ◯ Stairs/Steps ◯ Shower Stall ◯ Combo Bathtub Shower
◯ Wheelchair Accessible ◯ Homemaker ◯ Custom

Durable Medical Equipment: *Select all that apply*
◯ Tub Bench ◯ Shower Chair ◯ Grab Bars ◯ bedside Commode ◯ Raised Toilet Seat ◯ Standard Walker
◯ Rolling Walker ◯ Hemi-walker ◯ Quad Cane ◯ Straight Cane ◯ Wheelchair

Tobacco Use: ◯ No ◯ Yes
Home Health Care: ◯ No ◯ Yes
History of Falls: ◯ No ◯ Yes

Medical History:
◯ **No Know Significant Past Medical History**
◯ Alzheimer's Disease
◯ Diabetes Type-1
◯ Fibromyalgia
◯ High Blood Pressure
◯ Hunting's Disease
◯ Muscular Dystrophy
◯ Osteoarthritis
◯ Rheumatoid Arthritis
◯ Other (describe):
◯ Cardiovascular Disease
◯ Current Infection
◯ Diabetes Type-2
◯ Fracture or Suspected Fracture
◯ History of Cancer
◯ Lupus
◯ Obesity
◯ Parkinson's Disease
◯ Traumatic Brain Injury

Diagnostic Testing / Imaging: ◯ No ◯ Yes Date: Type:

Check All That Apply:
◯ Latex Allergies ◯ Previous Therapy ◯ Litigation ◯ Psycho-Social
◯ Multiple Treatment Areas ◯ Surgical History

Unexplained Weight Loss: ◯ No ◯ Yes

Current Medications With Dosages: (Please print a list or provide a copy for our records:)
◯ Prescriptions
◯ Over The Counter
◯ Herbals
◯ Other
◯ Not currently taking any medications