METRO Hand Therapy

275 Carpenter Dr NE Ste 210
Atlanta, GA 30328
Phone: (404) 965-1595
Fax: (404) 390-1024

PATIENT INFORMATION

First Name: | Last Name: | Middle Initial: | Date: / /

Address: | City: | State: | Zip:

Email Address:

Birth Date: / / | Age: | ☐ Male ☐ Female | S.S. #: - -

Home Phone: ( ) - | Alternative Phone (Cell, Pager): ( ) - | Spouse:

Chose Clinic Because/ Referred to Clinic by Dr.: ☐ Insurance Plan ☐ Word of Mouth:

☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement

WORK INFORMATION

Employer: | Work Phone: ( ) - | Ext.

Occupation: | Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION

Referring Dr: | Phone: ( ) -

Regular Dr./PCP | Phone: ( ) -

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (If different): | Birth Date: / /

ID. #: | Group/Policy #: | Policy Holder's SSN:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:

Subscriber's Name: | Birth Date: / /

ID. #: | Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

AUTO OR WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto: ☐ Labor & Industries:

Adjuster/Claim Manager: | Phone: | Ext.:

Address: | City | State: | Zip:

Claim #: | Accident Date: / / | Cause:

IN CASE OF EMERGENCY

Name of Local Relative or Friend:

Relationship to Patient: | Home Phone: ( ) - | Work Phone: ( ) -

Please provide the name of the person(s) to whom Metro Hand Therapy Associates, P.C. may disclose health information

Name: | Relationship to Patient: | Phone: ( ) -

May we send an email or leave messages regarding appointments or treatment on your answering machine? ☐ Yes ☐ No

I authorize my insurance benefits be paid directly to Metro Hand Therapy. I understand that I am financially responsible for any balance. I also authorize Metro Hand Therapy to release any information required to process my claims.

Patient Name (Print): _____ Date: _____

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐

Other: _____

EXERCISE
- ☐ None
- ☐ 1-2 x Week
- ☐ 3-4 x Week
- ☐ 5+ x Week

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor
- ☐ Other

What types of exercise do you perform?

What things cause stress in your life?

STRESS LEVEL
- ☐ Low
- ☐ Medium
- ☐ High

HABITS
- ☐ Smoking — Packs a Day _____
- ☐ Alcohol — Drinks a Week _____
- ☐ Coffee/Soda — Cups a Week _____

Are you taking any seizure medication? ☐ Yes ☐ No If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ Yes ☐ No If yes list name: _____

List all medications you are currently taking: _____

List all surgeries (including dates): _____

Are you pregnant? ☐ Yes ☐ No What week?

Have you had any injuries related to work? ☐ Yes ☐ NoIf yes list body part and date.: _____

Have you had any auto accidents? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had Hand Therapy or Massage Therapy before? ☐ Yes ☐ No Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

Pain and Symptom Status Report

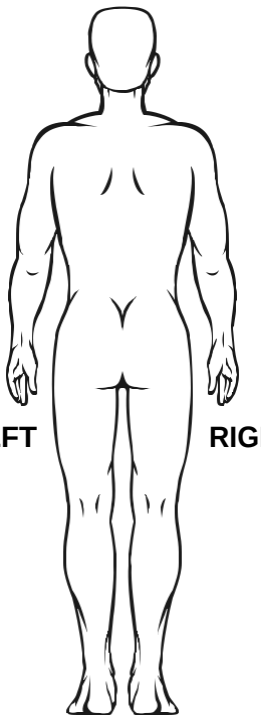
Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, they type of pain you are experiencing.

Ache	Burning	Numbness
MMM	— — —	0000
M	— —	0 0 0

Pins and Needles	Stabbing	Other
□□□□□□	/////	x x x x
□□□□	////	x x x

RIGHT **LEFT**



LEFT **RIGHT**

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>LOWEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>HIGEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

What goals do you wish to achieve in hand therapy? _____

_____

_____

_____

_____