Established Patient Encounter Form

Please complete information below

Today's Date: ____/_____/_____

Name: _____ **DOB**_____/_____/_____ **Male** **Female**

Goal for today's visit: _____

What body part are you being seen for today? _____**Affected side(s):** Right Left

Circle the symptoms that best describe your problem: Stiffness Pain Instability Numbness Swelling Weakness Sensitivity Other_____

If you have pain, please circle the appropriate description:

Sharp Throbbing Aching Burning Stabbing Heavy Dull Zinging Tightness

Circle the number corresponding to the intensity of your pain: (0 = no pain and 10 = the worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Any changes in your symptoms since your last visit?

Better Gradually Better Rapidly Worse Gradually Worse Rapidly Staying the Same

Circle what **improves** your symptoms

Rest Ice Heat NSAID Splinting Massage

Circle what **worsens** your symptoms

Activity Cold Pressure

Have you had steroid injections in the past?

Yes ___ No___ Body part: _____

Did it help? Yes ___ No ___

Other treatments for this condition? (not done here)

_____

_____

Are you currently attending hand/occupational therapy?

Yes No

If yes, where? (ex. Here, PINN, Cascade Hand Therapy, etc)

_____

Are you more interested in the following treatment:

Conservative (Non-surgical) Surgical Unsure

What is your work status? Employed Unemployed Disability Student Retired

Occupation_____ Employer_____

☑

Current Review of Systems

Check any conditions and symptoms you ***currently*** have:

		Comments
General (weight gain/loss, fatigue, insomnia, fever/chills)		
Eyes (glasses/contacts, cataracts, glaucoma)		
Ear/Nose/Throat (sinus trouble, hearing loss)		
Heart (chest pain, high blood pressure, coronary artery disease, irregular heartbeat)		
Lungs (shortness of breath, asthma, lung disease)		
Stomach (heartburn, nausea, diarrhea, hepatitis)		
Muscle / Bones (joint pain, muscle pain, arthritis, fractures, sprains)		
Urinary Tract (painful urinating, kidney stones, prostate)		
Skin (masses, blisters, dermatitis, eczema)		
Neurologic (seizures, numbness/tingling)		
Mental Health (anxiety, depression)		
Endocrine (frequent urination, excessive thirst, diabetes, hypothyroid)		
Hematological (bleeding/clotting problems, anemia, swollen lymph nodes)		
Allergic / Immunologic(HIV/AIDS, hay fever lupus)		

WORKER'S COMPENSATION CLAIMS ONLY

Worker's Comp. Insurance_____ **Do you have an attorney?** Yes No

Claim number: _____ **DOI:** _____/_____/_____

Circle your work status or provide additional information in the "other" box below:

Currently Working Currently working with restrictions Not Working Other _____

What are your restrictions? _____

If NOT working, when did you last work? _____/_____/_____

Any new treatments or programs the staff should be aware about? (i.e. SIMP, IME, FCE, new condition added)

_____

_____

_____