Health Questionaire P1 Wrist

Orthopedic Institute Of Michigan Physical Therapy Clinic

Name: Date:

Referring Doctor | Gender: M F | Age:

Sports / Hobbies: Weight :

Occupation;

Information in regards to your injury

Date of Injury / Onset | Date of Surgery (if indicated)

Body part to be Treated

Is this the first injury you have had to this area ? Yes No

Past treatment (if indicated)

Do you have any of the following ?

#	Condition	Yes	No
1	Diabetes?	Yes	No
2	Cardiac pacemaker ?	Yes	No
3	Any total Joint replacments? Where?	Yes	No
4	Arthritis ? Where?	Yes	No
5	Unexpected weight loss ?	Yes	No
6	Headaches /Migraine	Yes	No
7	Do you smoke ?	Yes	No
8	History of cancer in the family ?	Yes	No
9	History of cancer ? Where?	Yes	No
10	Had previous surgery ?	Yes	No
11	Depression due to the illness ?	Yes	No
12	Psychiatric illness ?	Yes	No
13	Pregnacy ?	Yes	No
14	Heart disease ?	Yes	No
15	High / low blood pressure ?	Yes	No
16	Lung disease ?	Yes	No
17	Decreased circulation (hands/forearm, feet /legs)	Yes	No
18	Neck or back pain ?	Yes	No
19	Arteriosclerosis	Yes	No
20	Other illnesses ?	Yes	No

Health Questionaire P2

Orthopedic Institute Of Michigan Physical Therapy Clinic

Name:		Date:	

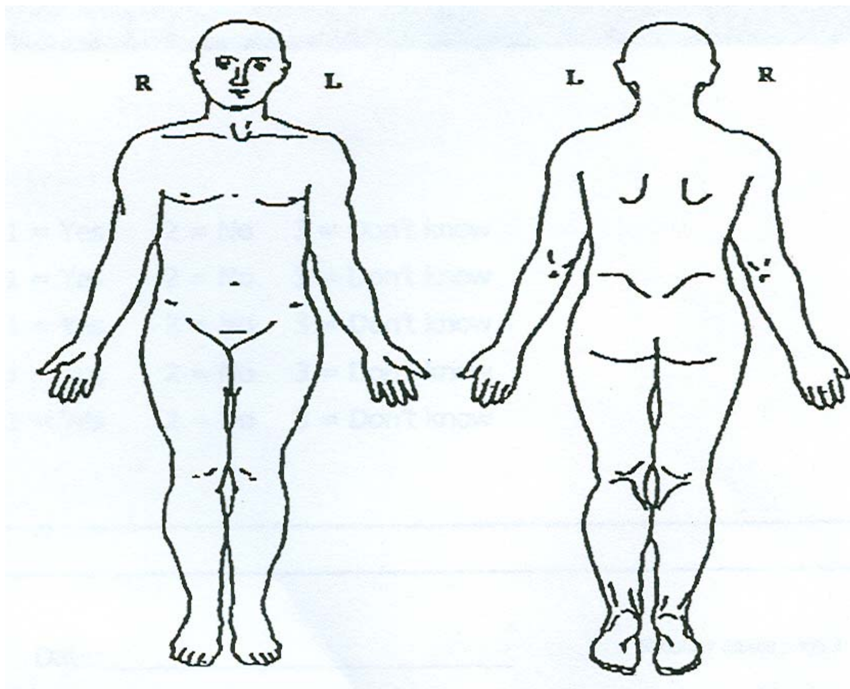
Medication

List your medications and reason for taking them:

How does the pain affect you?

0= pain free, 2= discomfort, 5= Modertate, 8= severe 10= Excruciating

	Circle the score the best reflects your status
1 The WORST pain you have had in the last week	**1 2 3 4 5 6 7 8 9 10**
2 Your CURRENT pain.	**1 2 3 4 5 6 7 8 9 10**
3 The LEAST pain you have had in the last week:	**1 2 3 4 5 6 7 8 9 10**
4 Circle the DURATION of your pain:	**Brief Intermittent Constant**
5 Circle your MEDICATION use:	**None As needed Constant**



Mark your pain on the diagram above

Describe your pain: ache, throbing, burning, shooting, sharp, pins/needles, numbness

Wrist and Hand Questionaire

Orthopedic Institute Of Michigan Physical Therapy Clinic

Name:		**Date:**	

Please score the following activities as follows

1= able with out difficulty 2= Able with some limitation 3= Difficult
4= Very difficult 5= Unable

#	Activity					
1	Make a closed	**1**	**2**	**3**	**4**	**5**
2	Write legibly	**1**	**2**	**3**	**4**	**5**
3	Fasten your seat belt	**1**	**2**	**3**	**4**	**5**
4	Start the car	**1**	**2**	**3**	**4**	**5**
5	Bruth teeth	**1**	**2**	**3**	**4**	**5**
6	Get dressed	**1**	**2**	**3**	**4**	**5**
7	Wipe after bowel movement	**1**	**2**	**3**	**4**	**5**
8	Eat with the involved side	**1**	**2**	**3**	**4**	**5**
9	Comb hair with the involved side	**1**	**2**	**3**	**4**	**5**
10	Lift a glass or cup	**1**	**2**	**3**	**4**	**5**
11	Lift a full sized pan from the stove	**1**	**2**	**3**	**4**	**5**
12	Lift groceries into a shopping cart	**1**	**2**	**3**	**4**	**5**
13	Perform work duties with ease	**1**	**2**	**3**	**4**	**5**
14	Prepare your own food	**1**	**2**	**3**	**4**	**5**

Which activities ease the pain?____

Since the injury/Sugery has the pain become A- Worse B- The same C- Better