Neuromuscular Therapy ● Confidential Client Information

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Hand/Wrist Pain Severity Intake Form

Name_____**Home #**_____

Address_____**Cell #**_____

City _____**State**_____**Zip**_____**Date of Birth (month/day)**_____

Email_____**Sex**_____**Occupation**_____**Referred by**_____

Primary reason for visit_____

Specific goals you hope to achieve coming here _____

How long have you had hand/wrist pain_____

How did your wrist/hand pain arise_____

Are there any specific activities which aggravate your pain or discomfort_____

Does your hand/wrist pain keep you awake at night_____

Describe the nature of pain. Sharp, dull, burning, aching, diffuse, electrical, etc._____

What have you tried, present and past, for your condition_____

Was it successful and did it help at all...Describe_____

Any MRI's/X-Rays/Bone Scans, etc...Describe_____

Are you taking medications_____**Describe**_____

Are there any side-effects to your medication you're aware of_____**Describe**_____

Do you have any shooting pain, numbness, or tingling down your arms/hands_____**Describe**_____

Do you have any bulging or herniated discs that you know of_____**Describe**_____

Is your condition affecting/limiting ANY activities or exercise/sports _____

Have you ever had this or a similar condition before. If so, how was it resolved?_____

Have you noticed your posture affected by your condition_____

How many hours do you sit each day_____

What concerns you the most about your condition (your biggest fear)_____

What aspect of your life are you missing most and is most affected by your condition...i.e. sports, work, sex, daily activities, family, picking up your kids, etc._____

What do you hope will happen once you successfully complete treatment_____

What will happen to you if I can't help, your problem isn't solved, or I don't accept you for treatment_____
_____

Please check any of the following which apply to you, past or present:

__accident	__blood disorder	__cancer	__breast augmentation
__whiplash	__disc disorder	__heart attack	__broken bones
__neck pain	__low back pain	__seizures	__high blood pressure
__surgery	__abdominal pain	__headaches	__varicose veins
__bursitis	__carpal tunnel syndrome	__diabetes	__joint aches/arthritis
__HIV/Aids	__strains/sprain	__hepatitis	__decreased range of motion
__dizziness	__decreased strength	__hypoglycemia	__other

Please explain any checks in the space below with approximate date of each occurrence:

_____
_____

Please read the following and sign below:

I, _____understand that Neuromuscular Massage Therapy (NMT) given here is for the purpose of muscular spasm/tension relief related to soft-tissue dysfunction. I _____understand the treating therapist does not prescribe medical treatment, diagnose illness, disease or any other physical or mental disorder. I have been made aware that NMT is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. Because the treating therapist must be aware of existing condition, I have stated all my known medical conditions and take it upon myself to keep the treating therapist updated on my physical health. I understand that regardless of insurance reimbursements I am ultimately responsible for full payment of my account and payment is due at the time services are rendered. I understand that there is a 24 hour cancellation policy, and there will be a charge for late cancellation.

Signature _____ Date _____

Carpal Tunnel/Hand/Wrist Pain Specific Questions: Name_____

Do You Have Any Of These Symptoms? Please Check ALL That Apply And Describe When Necessary:

YES

□ Do you have pain, numbness, tingling, stiffness, burning, or swelling in your hands, elbows, forearms, or shoulder? Circle areas
□ Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger.
□ Do you get increased arm numbness when lying flat on your back or sleeping on your side?
□ Does changing your sitting posture increase your arm/hand symptom intensity?
□ If you sit and slouch forward for several minutes, do your arm symptoms intensify?
□ If you have arm symptoms, do they improve when you lift your arms over your head?
□ If you have arm symptoms, do they worsen when you lift your arms over your head?
□ If you have hand or arm pain at night, does it help to shake and massage them?
□ Does ice or heat help or make it worse?
□ Do your hands feel tender when you grasp objects?
□ Do you feel weakness in your grip strength?
□ Do you drop objects from your hand?
□ Do you have difficulty writing or doing small motions with your fingers recently?
□ Do your hand(s) or wrist swell?
□ Do your hand(s) burn?
□ Are your fingers or hands frequently cold?
□ Have you been diagnosed as having Carpal Tunnel Syndrome or Raynaud's syndrome in your past?
□ Is it difficult to straighten your elbow?
□ Do you have burning or prickling sensation in the palm of your hand?
□ Do you wake up in the morning or at night with hands numb or in pain?
□ Are your symptoms worse in the morning, nighttime, daytime?
□ Other

Please Check/Circle ANY Of These Possible CAUSES For Your Hand/Wrist Pain And Describe When Necessary:

□ Carrying heavy bags of groceries, carrying baby around, picking up growing children, carrying purse hanging on the forearm.
□ Pulling yourself up too many times to the chin-up bar or any other strained flexing of your elbow.
□ Working and typing all day at a computer keyboard
□ Sitting all day at desk
□ Whiplash or car accident recently
□ Playing musical instrument: oboe, clarinet, saxophone (numbness in thumb of right hand)
□ Tennis, golf, typing, or stirring cookie dough
□ Sleeping with wrists bent severely inward
□ Sleeping on side or face down
□ Long car trip with hard grip on steering wheel
□ Weeding the yard, sewing, needlepoint, constant use of scissors
□ Holding heavy tools for long hours or any repetitive action of the elbow on the job
□ Recent anxiety, stress, breathing difficulties
□ High blood pressure, heart problems, TMJ dysfunction (jaw pain)
□ Heavy alcohol drinking
□ Current or recent pregnancy
□ Other