HHR
Hawaii Hand & Rehabilitation Services LLC

MEDICAL QUESTIONNAIRE

Patient Name:_____

What problem/diagnosis brings you here today?_____

Side of Injury ☐ **R** ☐ **L** **Date of Injury:**_____ **Date of Surgery**_____

Have you received therapy for this condition before? yes_____ **no**_____

Have you received outpatient therapy services this calendar year? (indicate # of visits) PT____ **OT**____

Have you had a similar condition before? ☒ **yes** ☐ **no** **If yes, when?**_____

Is this injury/condition related to an incident in which another party may be responsible?

Check one: workers compensation ◯ **/ No Fault motor vehicle accident** ◯ **/ other** ◯

If so, whom is suspected of being responsible?

_____

Claim #:_____

Contact/Adjuster Name/Phone #:_____

Case Manager Name/Phone#:_____

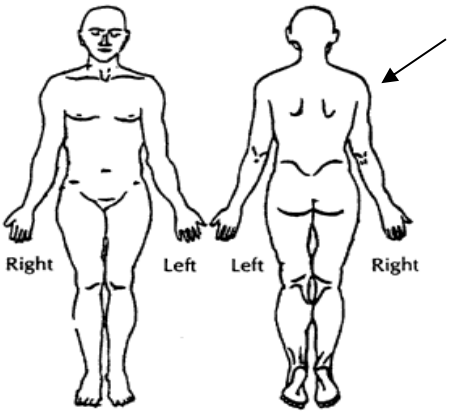
Have you hired or plan to hire an attorney to represent you in connection with this injury or illness?

Name of Attorney_____

Address/Phone:_____

Describe how this injury/condition occurred:_____

Current occupation:_____ ☐ **Regular Duty** ☐ **Light Duty**



Shade areas of your pain/discomfort on the figure to the left

Rate your pain on a scale from 0-10 (0=no pain;10=emergency room)

Current ○ **0** ○ **1** ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10**

At best ○ **0** ○ **1** ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10**

At worst ○ **0** ○ **1** ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10**

What makes your pain better:_____

What makes your pain worse:_____

What activities at home, work or recreation are you unable to perform?_____

Goals for therapy:_____

Current medications:_____

Allergies:_____