the HandClinic of Austin

Confidential Medical Information

Date of injury/onset_____

Current Issues _____

_____

Are you currently being treated by:

Another therapist	Yes	☐	No	☐	Or within the last 12 months	Yes	☐	No ☐
Chiropractor/Osteopath	Yes	☐	No	☐	Or within the last 12 months	Yes	☐	No ☐
Home health agency	Yes	☐	No	☐	Or within the last 12 months	Yes	☐	No ☐

Major surgeries _____

Allergies _____

Current Medications _____

Check if you currently or previously had any of the following:

☐ Arthritis
☐ Asthma
☐ Cancer
☐ Circulation problems
☐ Diabetes
☐ Heart problems
☐ High blood pressure
☐ Gout
☐ Seizures
☐ Stroke
☐ Ulcers
☐ Other illness

Specify _____

_____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of the medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ Date _____