

Outpatient Rehabilitation Services

Medical History/Subjective Information (Hand Therapy)

Name: _____ Date: _____ Date of Birth: _____

Occupation: _____ Weight: _____ Do you smoke: Yes No

Circle: Right handed Left handed Do you feel safe in your home/living environment? Yes No

Upon discharge from therapy, your home/living environment will be:

Private home/apt _____ Assisted living _____ Board and care _____ Other _____

Is there anyone in your home/living environment available to assist you with home care? Yes No

Do you have any cultural, language or other special needs we should be aware of? Yes No

If yes, please specify: _____

Where is your injury/condition located? _____ Date of injury: _____

(Indicate each injury on body chart below)

R L L R

Your main symptom: Pain _____ Numbness _____ Tingling _____

Other: _____

How did your injury/condition occur? _____

Is your pain:

Getting better _____ Getting worse _____ Staying same _____

Circle your range of pain (0 = no pain, 10 = the most pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

What improves your pain/symptoms? _____

What functions/activities make your pain/symptoms worse? _____

What are your goals for treatment? _____

*Any significant other Diagnoses or Conditions?

Arthritis: Yes No If Yes, Date: _____

Diabetes: Yes No

Hepatitis: Yes No

Seizure: Yes No

Unexplained weight loss? Yes No

Tuberculosis(TB): Yes No

Cancer: Yes No

Heart Condition: Yes No; Hypertention: Yes No

Osteoporosis: Yes No

Stroke: Yes No If Yes, Date: _____

Other: _____

*Any Allergies (medication or otherwise): _____

*List all medications that you are currently taking (include Over-the-Counter /herbal/ and any medications you anticipate needing to self administer while onsite for therapy?): _____

*Past significant Operations/Surgeries: _____

List any diagnostic tests that you have had for this condition: X-Ray: Yes No MRI: Yes No

Other: _____

Have you been treated before or elsewhere for this injury/condition? If yes, please specify: _____

Form Completed By (if not by patient): _____

Reviewed By: _____

(Therapist's Signature)



FUNCTIONAL QUESTIONNAIRE

Please circle tasks that have been most affected by your injury/condition. Please circle the number that best indicate how much the tasks has been affected.				
	1 = Cannot do at all	2 = Can do with great difficulty		
	3 = Can do with some difficulty	4 = Can perform without difficulty		
Use of fork/spoon	1	2	3	4
Cutting meat	1	2	3	4
Taking a jug out of the fridge	1	2	3	4
Opening a bottle, jar or can	1	2	3	4
Sleeping	1	2	3	4
Writing	1	2	3	4
Hair care	1	2	3	4
Brushing teeth	1	2	3	4
Buttoning/ Zippering	1	2	3	4
Putting on socks / shoes	1	2	3	4
Bathing / Showering	1	2	3	4
Dressing	1	2	3	4
Cleaning or scrubbing surfaces	1	2	3	4
Laundry	1	2	3	4
Vacuuming	1	2	3	4
Driving	1	2	3	4
Turning on the car ignition	1	2	3	4
Sports / Recreation	1	2	3	4
Carrying groceries/ grocery shopping	1	2	3	4
Opening doors	1	2	3	4
Reaching overhead	1	2	3	4
Reaching behind (for wallet, and/or fasten bra)	1	2	3	4
Daily job activities / work tasks	1	2	3	4
Gripping / Squeezing	1	2	3	4
Yard work	1	2	3	4
Other _____	1	2	3	4
Additional Comments:				

PATIENT NAME: _____