

## 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

\*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**

<b>Please circle tasks that have been most affected by your injury/condition.</b> <b>Please circle the number that best indicate how much the tasks has been affected.</b>				
	1 = <b>Cannot</b> do at all	2 = Can do with great difficulty		
	3 = Can do with some difficulty	4 = Can perform <b>without difficulty</b>		
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: \_\_\_\_\_