ORTHOPEDIC ASSOCIATES OF LANCASTER, LTD

Hand Therapy Intake Survey

Patient Name: _____ MRN: _____

Gender: Male Female DOB: _____

Body Part: _____ Date: _____

Therapist: _____ Office Location: _____

Doctor: _____ Next Doctor Appt: _____

SUBJECTIVE HISTORY

1. What is your date of injury/onset of symptoms? _____
2. How did you injure yourself? _____
   _____
3. Have you had any of the following?
   ☐ X-Rays ☐CT Scan ☐MRI ☐EMG/Nerve Conduction Test ☐Other_____
4. Have you had any prior occurrences of this condition? ☐Yes ☐No
   If yes, explain: _____
5. Have you had any prior treatments/surgeries for this injury/condition? ☐Yes ☐No
   If yes, explain: _____
6. Due to your physical ailment, do you feel a need for or want a social worker to contact you? ☐Yes ☐No

CURRENT COMPLAINT

7. What is your chief complaint? _____
8. What makes your pain BETTER? _____
9. What makes your pain WORSE? _____

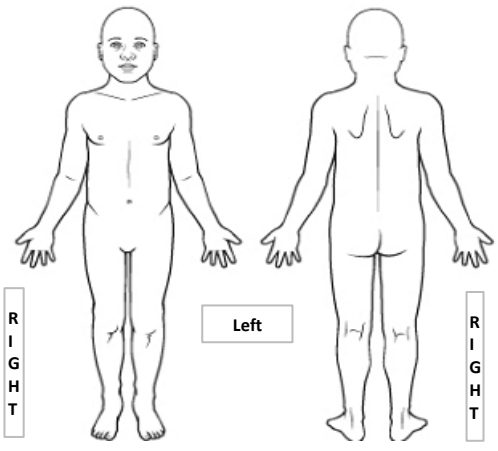
PAIN SCALE

10. If you have pain, what is your pain level? 0= No Pain, 10= Extreme pain

CURRENT Pain Level:
0 1 2 3 4 5 6 7 8 9 10

Pain level at BEST:
0 1 2 3 4 5 6 7 8 9 10

Pain level at WORST:
0 1 2 3 4 5 6 7 8 9 10



Mark the location of your pain with "X"

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MEDICAL HISTORY

11. Complete your medical history below by checking the appropriate box ☐ Refer to EPIC EMR

☐ Allergies	☐ Heart Disease	☐ Physical Abnormalities
☐ Anemia	☐ Heart Palpitations	☐ Polio
☐ Asthma	☐ Heat/Cold Intolerance	☐ Pregnancy (current)
☐ Bladder/Bowel Abnormalities	☐ Hernia	☐ Recent Fractures
☐ Cancer	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Chest Pain/Angina	☐ Hypoglycemia	☐ Ringing of Ears
☐ Depression	☐ Kidney Problems	☐ Seizures/Epilepsy
☐ Diabetes I/II	☐ Liver Problems	☐ Sexual Dysfunction
☐ Dizziness/Fainting	☐ Metal Implants	☐ Skin Abnormalities
☐ Fever	☐ Nausea/Vomitting	☐ Smoking History
☐ Fibromyalgia	☐ Night Pain	☐ Stroke/TIA
☐ Gallbladder Problems	☐ Osteoarthritis	☐ Surgeries
☐ Headaches	☐ Osteoporosis	☐ Urine Leakage
☐ Heart Attack	☐ Pacemaker	☐ Other_____

12. Is there any other information regarding your medical history that we should know about?

_____

_____

SOCIAL HISTORY

13. Do you live: ☐Alone ☐With Spouse ☐With Family ☐Other_____

14. Do you have stairs? ☐Yes ☐No If yes, how many? _____

    Do you have a handrail? ☐Yes ☐No

15. How are your interests/hobbies affected by your symptoms? _____

_____

_____

_____

MEDICATIONS

16. Please list all of the medications that you are currently taking: _____

_____

_____

_____

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MEDICAL PRECAUTION/CONTRAINDICATIONS

17. Are there any factors that may complicate your ability to participate in therapy? ☐Yes ☐No

    If YES, please explain: _____

18. Have you fallen in the past 12 months? ☐Yes ☐No If YES, how many times? _____

19. If YES, please describe the nature of the fall(s) and if any injury occurred:

_____

_____

OCCUPATION/WORK STATUS

20. What is your occupation? _____

21. Are you presently working? ☐Yes ☐No

    If Yes, what is your status: ☐Full Duty ☐Limited Duty Explain: _____

22. Are you now or ever have been disabled (service at work)? ☐Yes ☐No

    If YES, when? _____

LEVEL OF FUNCTION

23. How were you functioning on a daily basis prior to your injury/illness? _____

_____

_____

24. How often have you completed at least 20 minutes of exercise (jogging/cycling/brisk walking) prior to the onset of your condition?

    ☐≥3 Times/Week ☐1-2 Times/Week ☐Seldom ☐Never

STATEMENT OF SELF-RELATED HEALTH

25. How would you classify your general health? ☐ Good ☐ Fair ☐ Poor

PHYSICAL THERAPY PATIENT GOALS

26. What are your goals for participating in therapy? _____

_____

_____

_____

27. This is a statement other patients have made. "***I should not do physical activities which (might) make my pain worse.*** "
    Please rate your level of agreement with this statement below.

    ☐ Completely Disagree
    ☐ Somewhat Disagree
    ☐ Unsure
    ☐ Somewhat Agree
    ☐ Completely Agree

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FUNCTIONAL/ADL ABILITY RESTRICTIONS

We are interested in how you feel about how well you are able to do you usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurrate.

Therapist Use Only:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE	DASH	FOTO
1. Put on a pull over sweater?	1	2	3	4	5		
2. Turn a key?	1	2	3	4	5		
3. Carry a small suitcase?	1	2	3	4	5		
4. Wash your back?	1	2	3	4	5		
5. Carry a shopping bag or briefcase?	1	2	3	4	5		
6. Do heavy household chores? (e.g. wash floors/walls)	1	2	3	4	5		
7. Launder clothes?	1	2	3	4	5		
8. Do up buttons?	1	2	3	4	5		
9. Open a tight or new jar?	1	2	3	4	5		
10. Open doors?	1	2	3	4	5		
11. Use a knife to cut food?	1	2	3	4	5		
12. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g. golf, hammering, tennis, etc.)?	1	2	3	4	5		

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY	DASH	FOTO
13. During the past week, to what extent has your arm, shoulder or hand problem interfeed with your normal social activities with famliy, friends, neighbors or groups?	1	2	3	4	5		

	NOT LIMITED	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE	DASH	FOTO
14. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5		

Rate the severity of the following symptoms in the past week	NONE	MILD	MODERATE	SEVERE	EXTREME	DASH	FOTO
15. Arm, Shoulder or hand pain	1	2	3	4	5		
16. Tingling (pins and needles) in your arm, shoulder or hand	1	2	3	4	5		

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE	DASH	FOTO
17. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	1	2	3	4	5		

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WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including

Please indicate what your job role/work is: _____

☐ I do not work. (You may skip this section)

Please circule the number that best describes your ability in the past week. Did you have any difficulty?

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE	DASH	FOTO
1. Using your usual technieque for your work?	1	2	3	4	5		
2. Doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5		
3. Doing your work as well as you would like?	1	2	3	4	5		
4. Spending your usual amount of time doing your work?	1	2	3	4	5		

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on palying your *musical instrument or*

Please indicate instrument/sport : _____

☐ I do not play a sport or instrument. (You may skip this section)

Please circule the number that best describes your physical ability in the past week. Did you have any difficulty?

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE	DASH	FOTO
1. Using your usual technique for playing your instrument or sport?	1	2	3	4	5		
2. Playing your instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5		
3. Playing your instrument or sport as well as you would like?	1	2	3	4	5		
4. Spending your usual amount of time practicing/playing your sport/instrument?	1	2	3	4	5		

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by (4); subtract 1; multiply by 25. **An optional module score may <u>not</u> be calculated if there are any missing items.**