GRANITE ORTHOPAEDICS

HAND THERAPY INTAKE

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Circle one: Male Female Circle one: Left-Handed Right-Handed

Occupation: _____

Answer the following questions as related to the condition for which you are attending hand therapy.

Referring Physician: _____

Is this a worker's compensation claim (work-related injury)? YES NO

Describe your injury, condition or surgery: _____

When did it start? _____

What happened? _____

Describe any treatments you have already had: _____

_____

What activities are you having difficulty with as a result of your injury, condition or surgery?

1. _____
2. _____
3. _____
4. _____

What are your goals for therapy? _____

_____

Work Information

Are you currently employed (circle one)? YES NO Job title: _____

What are your job duties/responsibilities? _____

_____

What is your work status? Full-duty Light-duty Off-duty Restrictions: _____

Rate Your Pain Using The Following Scale: 0 = No Pain 10 = Worst Pain Imaginable

When Your Pain Is At Its Worst: 0 1 2 3 4 5 6 7 8 9 10 (circle one)

When Your Pain Is At Its Best: 0 1 2 3 4 5 6 7 8 9 10 (circle one)

Where does it hurt: _____

What makes your pain worse: _____

What makes your pain better: _____

Do you have any numbness or tingling (circle one)? YES NO

If yes, describe the symptoms: _____

Medical History

Circle any past or current medical conditions you may have:

Pacemaker	Currently Pregnant	Brain Injury
Diabetes	High Blood Pressure	Neck Pain
Osteoarthritis	HIV/AIDS	Back Pain
Rheumatoid Arthritis	Stroke	Cancer: _____

Other conditions (please list): _____

List any allergies: _____

List medications you are currently taking: _____

_____

List any significant previous neck, shoulder, arm or hand injuries or surgeries you have had with approximate dates: _____

_____

Do you smoke? YES NO If yes, how many per day? _____

Do you drink alcohol? YES NO If yes, how much or how often? _____

Is there anything we need to know that is not covered on this form? If yes, explain below:

_____

QuickDASH

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. 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
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. 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

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5