



## INITIAL OT SUBJECTIVE EVALUATION (Hand, Wrist, Elbow, Upper Extremity)

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Dominant Hand: R L Sport/Activity: \_\_\_\_\_

Occupation: \_\_\_\_\_ Physical Demands: \_\_\_\_\_

Living Situation: Live Alone or with Spouse/Significant Other/Child/Children/Unrelated

History: Involved side: R L Both Shoulder Elbow Hand Wrist Fingers Thumb

Date of Onset/Injury/Surgery: \_\_\_\_\_

How did your problem occur: \_\_\_\_\_

Previous problems with arm or hand: \_\_\_\_\_

What is your chief complaint now: \_\_\_\_\_

Medical information

Physician: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Medical tests(circle): MRI x-rays CT Scan Bone scan EMG Other: \_\_\_\_\_

Surgery: Y N What type: \_\_\_\_\_

Did you use : sling cast splint other: \_\_\_\_\_

Previous therapy : Y N When: \_\_\_\_\_

Medications:

Other medical problems(circle): hypertension, diabetes, arthritis, cancer, pacemaker, allergies, stroke, pregnancy, other \_\_\_\_\_

Pain rating: Indicate your average level of pain by circling the number on the scale:

0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_ 9 \_\_\_ 10

mild moderate extreme agony

worst/highest pain level \_\_\_ best/lowest pain level \_\_\_

Is pain: constant \_\_\_ intermittent \_\_\_ throbbing \_\_\_ burning \_\_\_ stabbing \_\_\_ aching \_\_\_

Where is the pain located: \_\_\_\_\_

Activities that increase pain: \_\_\_\_\_

Activities that decrease pain: - \_\_\_\_\_

Other symptoms(circle): neck pain shoulder pain elbow pain wrist or finger locking swelling deformity weakness radiating pain numbness/tingling skin temp/color change

Function: Indicate with the following numbers the degree of difficulty for each activity:

0=unable 1=great difficulty 2=moderate difficulty 3=minimal difficulty 4=no difficulty

\_\_\_ type/use keyboard \_\_\_ drive car \_\_\_ open/close buttons

\_\_\_ lean on hand \_\_\_ pull up zipper \_\_\_ place hand in pocket

\_\_\_ tie shoes \_\_\_ receive change \_\_\_ brush teeth

\_\_\_ housework \_\_\_ lift cup/mug \_\_\_ yardwork

\_\_\_ lift carton \_\_\_ usual work

What goals do you hope to accomplish in Occupational Therapy \_\_\_\_\_

At the present time, would you say your health is excellent, very good, good, fair, or poor?

What activity/hobby/sport would you like to resume \_\_\_\_\_

When is your next doctor's appointment: \_\_\_\_\_

Patient signature: \_\_\_\_\_

Reviewed by therapist: \_\_\_\_\_ # \_\_\_\_\_ Date: \_\_\_\_\_