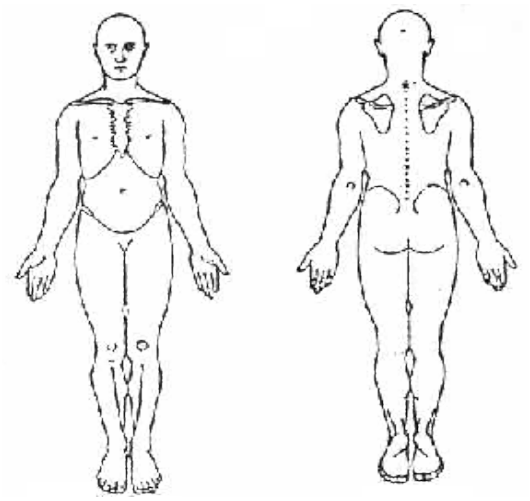
JOHN MUIR HEALTH

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)

*****Summary List Components – Joint Commission Standard RC.02.01.07

JOHN MUIR HEALTH

FUNCTIONAL QUESTIONAIRE

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:_____