

Patient Basic Information

Personal Information:

Last Name:		First Name:	Mid. Init.:
Address:		City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:	
Date of Birth:		Date of Injury/Onset:	
Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both			
Insurance Information: Policy Holder (if different than patient):			Policy No.:

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ___ Drying hair ___ Brushing teeth ___ Putting on shoes ___ Preparing meals ___ Taking out trash .. ___
 Showering ___ Combing hair ___ Making bed ___ Tying shoes ___ Eating ___ Doing laundry ___
 Washing hair .. ___ Washing face ___ Putting on shirt ___ Putting on pants ___ Cleaning dishes ___ Going to toilet ___

Difficulties with Physical Activities

Standing ___ Walking ___ Kneeling ___ Bending back ___ Twisting left ___ Leaning back ___
 Sitting ___ Stooping ___ Reaching ___ Bending left ___ Twisting right ___ Leaning left ___
 Reclining ___ Squatting ___ Bending forward .. ___ Bending right ___ Leaning forward ___ Leaning right ___
 Standing for long periods ___ Sitting for long periods..... ___ Walking for long periods..... ___ Kneeling for long periods ___

Difficulties with Functional Activities

Carrying small objects ___ Lifting weights off floor ___ Pushing things while seated ___ Exercising upper body ___
 Carrying large objects ___ Lifting weights off table ___ Pushing things while standing .. ___ Exercising lower body ___
 Carrying brief case ___ Climbing stairs ___ Pulling things while seated ___ Exercising arms ___
 Carrying large purse ___ Climbing inclines ___ Pulling things while standing ___ Exercising legs ___

Difficulties with Social and Recreational Activities

Bowling ___ Jogging ___ Swimming ___ Ice Skating ___ Competitive Sports . ___ Dating ___
 Golfing ___ Dancing ___ Skiing ___ Roller Skating ___ Hobbies ___ Dining out ___

Difficulties with Travelling

Driving a motor vehicle ___ Riding as a passenger in a motor vehicle ___ Riding as a passenger on a train ___
 Driving for long periods of time ___ Riding as a passenger on an airplane ___ Riding as a passenger for long periods ___

Use the following **1 to 5** scale to describe the difficulties below:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating.... ___ Hearing.... ___ Listening.... ___ Speaking.... ___ Reading.... ___ Writing.... ___ Using a keyboard.... ___

Difficulties with the Senses

Seeing..... ___ Hearing..... ___ Sense of touch..... ___ Sense of taste..... ___ Sense of smell..... ___

Difficulties with Hand Functions

Grasping..... ___ Holding..... ___ Pinching..... ___ Percussive movements..... ___ Sensory discrimination..... ___

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep..... ___ Being able to participate in desired sexual activity..... ___

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
- My current complaints DID exist before, but have not been bothering me.
- My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
- My history HAS NOT contributed to my current symptoms.
- I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred..... ___ months ago / years ago **Or on** Date: ___/___/___

Write in below any other Prior Symptom History, not covered above: