# 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 | ____writing |

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:_____

## CONSENT FOR CARE AND TREATMENT

I, the undersigned, having legal authority to do so, do hereby agree and give consent for Towson Sports Medicine to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and/or mental condition.

## HIPAA

I, the undersigned, have been made aware of my rights as a patient under the “Health and Information Portabilty and Accountability Act” as posted in the office. I further understand that I may request a printed copy of these rights at any time.

## MISSED APPOINTMENTS

Towson Sports Medicine requires that you give us **24 hours** notice of cancellations. If 24 hour advanced notice is not given, you may receive a **$50.00** missed appointment fee. Please contact **410-337-8847** to cancel appointments. This policy does not apply in situations of extreme weather. We also ask that you bring your appointment slip to each appointment.

### Thank You!

I have read and understand the statements noted above.

Patient/Guardian/Responsible Party_____ Date_____

Please Print Your Name_____ Date_____

Towson Sports Medicine Representative_____ Date_____