

**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, <i>to what extent</i> 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