OSPTA
ORTHOPEDIC & SPORTS PHYSICAL THERAPY ASSOCIATES

UPPER EXTREMITY

Name _____ Preferred name _____

Date of birth ____/____/____ Age ____ Sex: M / F Occupation _____

Referring physician _____ Primary care physician _____

Most recent medical exam ____/____/____ Next exam ____/____/____

For this condition, have you seen any other medical providers? Y / N – please list _____

_____

MEDICAL HISTORY

□Arthritis (□Osteoarthritis □Rheumatoid)
□Fibromyalgia □Other)
□Osteoporosis / □Osteopenia
□Asthma
□Chronic obstructive pulmonary disease (COPD)
□Respiratory distress syndrome (ARDS)
□Emphysema □Chronic bronchitis
□Angina or □Irregular heartbeat
□Congestive heart failure or heart disease
□Heart attack (myocardial infarction)
□High blood pressure
□Neurological disease
(Such as □multiple sclerosis □Parkinson's)
□Stroke or TIA
□Peripheral Vascular Disease
□Headaches
□Diabetes (□Type I / □Type II)
□Previous accidents (explain/give dates below)

□Visual impairment (□cataract □glaucoma
□macular degeneration)
□Hearing impairment (□hard of hearing □hearing aids)
□Back pain (□neck pain □low back pain
□degenerative disc disease □spinal stenosis)
□Kidney, □bladder, □prostate, □urination problems
□Incontinence
□Hypothyroid / □ Hyperthyroid
□Allergies: _____
□Anxiety □panic disorders □depression □other disorders
□Hepatitis / □AIDS
□Prior surgery (list below)
□Prosthesis / Implants
□Sleep dysfunction
□Cancer (Type_____)
□Gastrointestinal disease (□ulcer □hernia
□reflux □bowel □liver □gall bladder)
□Gynecologic problems (#children____ #pregnancies ___)

Please clarify any checked items above and provide other medical information _____

_____

_____

List surgeries/dates _____

_____

Family medical problems _____

Last eye exam: _____ What is your hand dominance? □Right □Left

□Smoking - # pack(s)/day_____ □Alcohol - # drink(s)/day_____ □Other substance use _____

Have you recently experienced?

□Unexplained weight loss / gain
□Shortness of breath
□Illness / flu / virus
□Headaches
□Feeling unsteady or fear of falling
□Changes in appetite
□Fever / chills / sweats
□Nausea / vomiting
□Night pain
□Dizziness when getting up from resting flat
□Changes in bowel / □bladder function
□Sexual difficulty
□Dizziness / fainting
□Falls in the past year (number _____)

MEDICATIONS (include over-the-counter) □ I have a list of medications, and have attached it to this form

Drug name	Dosage	How often	Pill/liquid/ Spray/injection	Condition	New (Y/N)

MEDICAL TESTING (List tests related to your current problem – dates: actual or as closely as possible)

	Date performed	Facility where performed	Your understanding of results
□ X –ray	_____	_____	_____
□MRI □CT Scan	_____	_____	_____
□Blood/Urine	_____	_____	_____
□Other	_____	_____	_____

ACTIVITIES: mark those you are currently active with and how many times/week

□Walking □Running □Bicycling □Weights □Swimming □Exercise class_____

□Golf □Tennis □Basketball □Skiing □Soccer □Gardening □Other

_____

How many days/week? _____ Duration each day _____

This is a statement other patients have made. *"I should not do physical activities which (might) make my pain worse."* Please rate your level of agreement with this statement below. (☑Response)

□Completely agree □Somewhat agree □Unsure □Somewhat Disagree □Completely Disagree

CURRENT PROBLEM/REASON YOU ARE HERE:

Describe in your own words _____

ONSET:

□0-7 days □8-14 days □15-21 days □22-90 days □91 days – 6 months □ > 6 months Date: _____

Did it begin □ suddenly or □ gradually what, if known, caused your problem?

_____

Is your problem getting □ better □worse □not changing?

Just before your problem began, were you completely free of discomfort or problems with the area? Y / N

Describe prior episodes including date(s), cause, duration and treatments

_____

PAIN RATING ***right now*** (Circle below)

0 1 2 3 4 5 6 7 8 9 10

No pain worst imaginable pain

0-10 pain over the ***past two weeks*** when at its best/lowest: _____ / 10 worst/highest: ____/10

DESCRIPTION OF DISCOMFORT:

□Ache □Pain □Sharp □Dull □Pins/needles □Tingling □Numbness
□Burning □Throbbing □Cramping □Swelling □Other _____

Is your problem/discomfort □Constant □Intermittent – if so, how often/how long lasting _____

How long can you be symptom free _____ Does coughing or sneezing cause discomfort? Y / N

Does the time of day affect your problem? Y / N When is it better? _____ Worse _____

How does rest affect your problem? □Relieves □Makes worse □No change

What activities/positions aggravate your problem? _____

What activity/positions relieve/decrease your problem? _____

Does discomfort ever awaken you at night? Y / N If yes, # times/night _____ Can you return to sleep? Y / N

Have you had previous physical therapy for this problem? Y / N what was the outcome? _____

Please let us know your goals/expectations: _____

_____

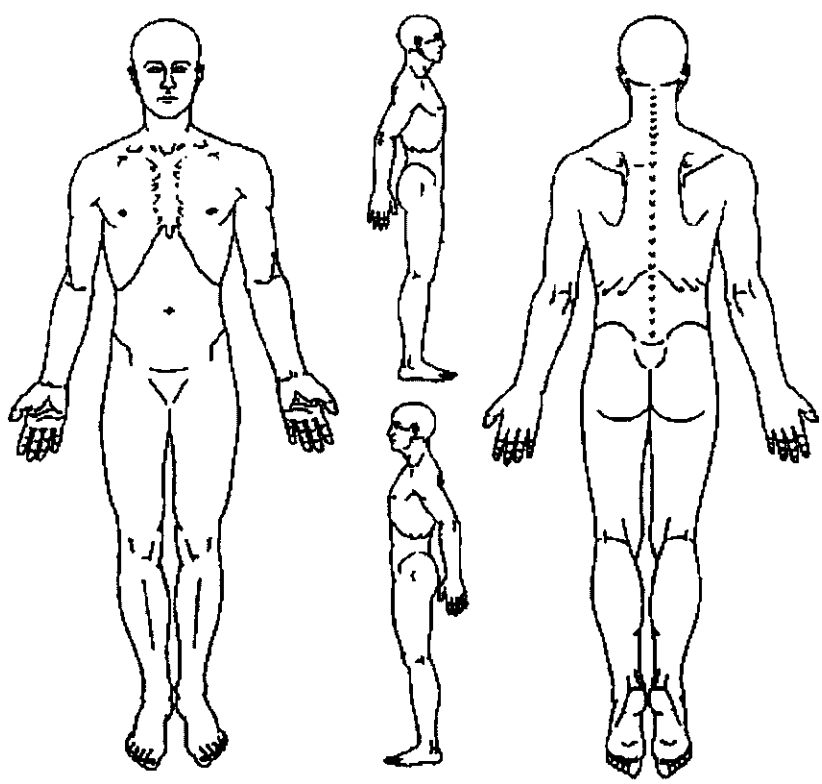
LOCATION OF SYMPTOMS:

When your problem began, was your discomfort in exactly the same location as you have it now? Y / N
If the position of the discomfort has changed, how did it progress from the original location?

_____

Please mark on the body diagram below (with the designated signs) exactly where your current problem is

- ✓ Minimal to moderate pain
- ➡ Radiating pain
- ■ Severe pain
- XX Numbness



Office use only
BP _____ HR _____ Height _____ Weight _____ BMI _____

Name: _____ Date: _____

QuickDASH

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, *to what extent* 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

QuickDASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{sum of n responses}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A QuickDASH score may not be calculated if there is greater than 1 missing item.