Occupational Therapy – Patient Self-Assessment Form

Patient Name: ____________________ Date: ____________________

Referring Physician: ____________________ Age: ____ Height: ____ Weight: _____

Occupation: ____________________ Dominant hand: ___ Right ___ Left

Work status: ____________________

What work duties/activities give you the most difficulty: ____________________

Current problem: ____________________

What diagnostic tests have you had for this problem: XRAYS? Y / N results? ____________________
MRI? Y / N results? ____________________
OTHER? Y / N results? ____________________

What type of treatment have you had for this problem: OCC/PHYS THERAPY? Y / N SURGERY? Y / N
CHIROPRATOR? Y / N INJECTIONS? Y / N
OTHER? ____________________

What do you hope to accomplish with therapy: ____________________

When is your next follow-up appointment with your doctor: ____________________

Tobacco Use: [ ] current smoker How many per day? [ ]5 or less [ ]6-10 [ ]11-20 [ ]21-30 [ ]31 or more
[ ] former smoker How long has it been? [ ]<1mo [ ]1-3mo [ ]3-6mo [ ]6-12mo [ ]1-5yr [ ]5-10yr [ ]>10yr
[ ] never smoked ____________________

Please rate your ability to do the following activities in the last week by circling the appropriate number.

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. Open a tight or new jar	1	2	3	4	5
2. Write	1	2	3	4	5
3. Turn a key	1	2	3	4	5
4. Prepare a meal	1	2	3	4	5
5. Push open a heavy door	1	2	3	4	5
6. Place an object on a shelf	1	2	3	4	5
7. Perform heavy household chores (i.e. wash walls, floors, etc.)	1	2	3	4	5
8. Gardening or yard work	1	2	3	4	5
9. Make a bed	1	2	3	4	5
10. Dressing (i.e. pulling up pants, hooking a bra, buttons)	1	2	3	4	5
11. Carry a shopping bag or briefcase	1	2	3	4	5
12. Carry a heavy object (over 10 lbs.)	1	2	3	4	5
13. Wash or blow dry your hair	1	2	3	4	5
14. Use a knife to cut food	1	2	3	4	5
15. Recreational activities– simple or forceful (card playing, knitting, golf, etc.)	1	2	3	4	5

******* YOU MAY SKIP THE BOTTOM OF THIS FORM IF YOU'VE BEEN REFERRED BY AN EXCEL ORTHOPEDIC PHYSICIAN *******

PLEASE LIST ALL PAST SURGERIES & APPROXIMATE DATE:

PLEASE LIST ALL CURRENT MEDICATIONS:

PLEASE LIST ALL ALLERGIES INCLUDING REACTION:

PLEASE LIST YOUR COMPLETE MEDICAL HISTORY:

_ Heart disease _ High blood pressure _ Pacemaker _ Stroke _ Chest pain _ Cancer _ Diabetes _Hypoglycemia
_ Osteoporosis _ Scoliosis _ Fibromyalgia _ HIV/AIDS _ Hepatitis _ Tuberculosis _ Seizures _ Kidney problems
_ Osteopenia _ Heat/Cold sensitivity _ Latex allergy _ Asthma _ Fractures _ Implants _ Arthritis _ Respiratory disorder
_ Other ____________________

To the best of my knowledge, the information I have given is complete and true.

(patient signature) *(date)*