

Do you have sufficient energy for desired/required activities? Yes No

What improves your fatigue? _____

What makes it worse? _____

What time of day do you start to feel tired? _____

Morning Stiffness:

Is morning stiffness present? Yes No

If yes, how long does it last? _____

What makes your stiffness worse or better? _____

Pain:

Is pain a problem? Yes No

Where is your pain located? _____

Perception of present level of pain:

0
10
 No Pain Worse Pain

What makes your pain feel better? _____

Worse? _____

4. PRIOR AND CURRENT TREATMENTS:

List all prescriptions and Over the Counter meds (including ASA and Tylenol)

Name	Dose	Route	Frequency

Comments: _____

Vitamins, minerals, herbal and naturopathic products? _____

Allergies? _____

Overall, how has your general health been? _____

Any colds or flu in the past year? Yes No If yes, how often? _____
 Accidents? – home, work, driving _____

General health appearance: _____

Surgeries: _____

Hospitalizations, visits to ER's, specialists, last visit to GP: _____

Previous arthritis treatment:

Have you had any of the following treatments? Please check (T) all that apply.

- | | |
|--|--|
| <input type="checkbox"/> physiotherapy | <input type="checkbox"/> massage therapy |
| <input type="checkbox"/> occupational therapy | <input type="checkbox"/> podiatry |
| <input type="checkbox"/> chiropractic treatments | <input type="checkbox"/> naturopathy |
| <input type="checkbox"/> acupuncture | <input type="checkbox"/> other |

Please explain: _____

5. HEALTH HABITS

Diet:

Current weight: _____

Appetite: _____

Any recent weight loss / gain? Yes No

Problems or discomfort with swallowing? Yes No

Is your diet restricted in any way
(religion, medical condition, etc.?) Yes No

Heal well or properly? Yes No

Dental problems? Yes No

Exercise:

Involvement in any cardiovascular activity? Yes No
 If so, what type, how much and how often? _____

Involvement with a home exercise program? Yes No

Smoking:

How much? Attempts to quit? Interest in quitting now? _____

Caffeine intake: _____

Stress management:

To what degree has stress been a problem for you? _____

Comment on current sources of stress _____

Any big changes / stressors in the last year or two? _____

How do you normally deal with stress? Degree of success? _____

Who is most helpful to you during times of stress? _____

Sleep pattern:

Time to bed: _____ Time get out of bed _____ # of hours of sleep _____

Do you have any problems getting to sleep? Explain. _____

Use of sleep aides / techniques? Explain. _____

Do you awake at night? Yes No If yes, how many times? _____

How do you normally feel when you awake? _____

What factors are affecting your sleep? _____

C.A.G.E. Questionnaire:**YES****NO**

Have you ever felt you ought to cut down on your drinking (use of alcohol or drugs)?

Have people ever annoyed or angered you by criticizing your drinking (alcohol or drug use)?

Have you ever felt guilty (or bad) about your drinking (alcohol or drug use)?

Have you ever had a drink (or drug) to get you started in your day or to "steady your nerves"?

6. PATIENT'S PERSPECTIVE AND GOALS**Knowledge and beliefs about disease:**

What do you think has caused your arthritis? _____

What do you know about how your arthritis works? _____

Does your pain, fatigue and sleep patterns change from one day to the next or

remain fairly constant

Knowledge and beliefs about treatment:

What kinds of things have worked for you in the past to help you manage your arthritis?

What are the most important things that you do to keep healthy? _____

What other types of treatment have you tried that were not helpful? _____

Why do you think these treatments were not successful? _____

How does the disease impact on your life, and how would you like to change this? _____

How can we be most helpful to you at this point in time? _____

What are the most important results you hope you will receive from these treatments?

Where do you see yourself in 6 months? _____

7. PHYSICAL ACTIVITY / FUNCTIONAL ABILITY

Indicate areas of concern:

- | | |
|---|----------------------------------|
| <input type="checkbox"/> personal care | <input type="checkbox"/> leisure |
| <input type="checkbox"/> sexual functioning | <input type="checkbox"/> work |
| <input type="checkbox"/> homemaking | |

Living situation: _____

How has the disease changed your day to day activities? _____

What activities are you able to do? _____

What activities do you need to do? _____

How has the disease affected sexual functioning? _____

functional aspect: _____

human relations aspect: _____

8. SOCIAL SITUATION**Educational background:**

Highest level of education: _____

Interest in pursuing further training: Yes No

Family Geneogram/support:

Do family members understand the illness? Yes No
 Do family members provide physical support? Yes No
 Do family members provide emotional support? Yes No
 Any family-related problems or concerns? Yes No
 Comments? _____

Occupation:

Most recent work situation: _____
 If not working, when last worked: _____
 Plans to return to work: _____
 Previous type of work: _____

Financial situation:

Source of current financial income: _____
 Security of income: _____
 Level of assets: _____
 Are there extended health benefits? _____

9. PSYCHOLOGICAL FUNCTIONING**Response to illness:**

What does having this condition mean to you or your family? _____

Mood changes - Do you experience emotional distress? Yes _____ No _____

Depression/ sadness ___ mild ___ moderate ___ severe ___
 Anger/ frustration ___ mild ___ moderate ___ severe ___
 Fear/loneliness ___ mild ___ moderate ___ severe ___

How long do these feelings last for? _____

Coping skills:

How do you normally deal with these mood changes: _____

Other emotional support:

Friendship network, clubs, organizations _____

Signatures:

Physiotherapy Assessment

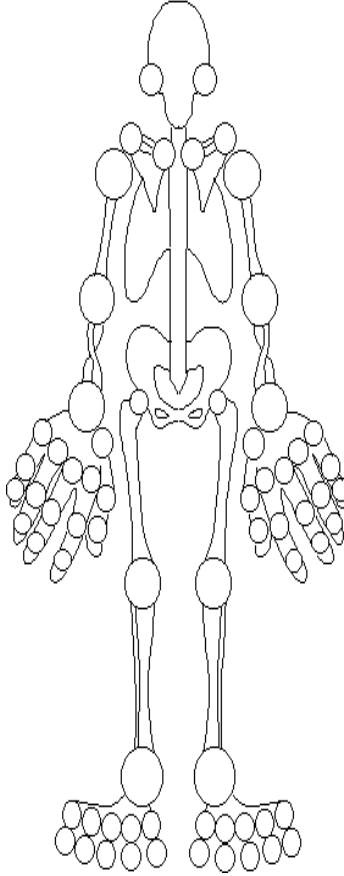
Inflammatory Joint Assessment

Name: _____

Date: _____

Physiotherapist: _____

Pain: Which joints are painful? _____

Shoulder(SC,AC) _____ _____ _____ _____	C/spine - _____ _____	Shoulder(SC,AC) _____ _____ _____ _____
Elbow _____ _____ _____	TMJ Opening _____ (R) _____ (L)	Elbow _____ _____ _____
Hand _____ _____ _____ _____ _____ _____		Hand _____ _____ _____ _____ _____ _____
Hip _____ _____ _____		Hip _____ _____ _____
Knee _____ _____ _____ _____ _____		Knee _____ _____ _____ _____ _____
Ankle/Hindfoot _____ _____ _____ _____		Ankle/Hindfoot _____ _____ _____ _____
Forefoot/MTP's _____ _____ _____	Disease Activity Tender (0) _____ Effusion (●) _____ Damaged (X) _____	Forefoot/MTP's _____ _____ _____

Range of Motion, Muscle Strength and Muscle Length/ Recruitment

Joint	Passive ROM		Muscle Strength		Other(muscle length/ recruitment, etc.)
	RT	LT	RT	LT	
C/spine Rotation Side flexion	_____	_____	_____	_____	
Shoulder Flexion Extension Abduction Ext. Rotation Int. Rotation	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	
Elbow Flexion Extension Supination Pronation	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	
Wrist Flexion Extension Radial Deviation Ulnar Deviation	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	
Hand Fist Tuck Pinch	_____ _____ _____	_____ _____ _____	Grip_____	Grip_____	
Hip Flexion Extension Abduction Ext. Rotation Int. Rotation	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	
Knee Flexion Extension	_____ _____	_____ _____	_____ _____	_____ _____	
Ankle Dorsiflexion Plantarflexion	_____ _____	_____ _____	_____ _____	_____ _____	
Subtalar Inversion Eversion	_____ _____	_____ _____	_____ _____	_____ _____	

Functional Performance (Stance, gait, balance etc)

Other assessment forms:
 hand _____ Other _____ spondylitis _____

O.T. Assessment

Name: _____

Therapist: _____ Date: _____

*

Musculo-Skeletal Review

Impact on Function

T.M.J.

Cervical Spine:

Shoulder:

Elbow:

Wrist:

Hands:

Back:

Hips:

Knees:

Ankles:

Feet:

Team Meeting with Patient

Date: _____

Problems Identified

1. _____

2. _____

3. _____

Goals

1. _____

2. _____

3. _____

Plan:

Estimated time on program: _____

PT: _____

OT: _____

MD: _____

SW: _____

RN: _____

