ACCIDENT INJURY THERAPY CENTER, INC.

24 Derby Avenue Derby, CT 06418 Telephone: 203-735-5555 Fax: 203-734-0447

FUNCTIONAL ACTIVITIES OF DAILY LIVING:

Initial /Re-evaluation /Final Exam Date:____

PATIENT NAME:___________________ DATE OF INJURY: ___________________________

PLEASE CHECK OFF ALL ACTIVITIES WITH WHICH YOU ARE HAVING DIFFICULTY AS A RESULT OF YOUR INJURY – DATE NOTED ABOVE.

Selfcare/Personal Hygiene 0 urinating 0 defecating 0 brushing teeth 0 combing hair 0 bathing 0 dressing oneself 0 eating	**Communication** 0 writing 0 typing 0 seeing 0 hearing 0 speaking	**Non-specialized hand activities** 0 grasping 0 lifting 0 tactile discrimination
Sleep 0 restful 0 nocturnal sleep pattern	**Family** 0 cooking meals 0 washing dishes 0 food shopping 0 floors/sweeping/washing 0 vacuuming 0 washing/drying clothes 0 folding clean clothes 0 ironing clothes 0 mowing lawn	**Sensory Function** 0 hearing 0 seeing 0 tactile feeling 0 tasting 0 smelling
Physical Activity 0 reclining 0 standing 0 sitting 0 bending 0 walking 0 climbing stairs	0 gardening 0 shoveling snow 0 computer use 0 taking out garbage 0 caring for children 0 caring for spouse 0 picking up children 0 changing diapers 0 sexual intercourse	**Recreational Activities and or sports with which you are having difficulty:** ______________________________ ______________________________ ______________________________
Travel 0 flying 0 driving a car 0 riding in a car 0 getting in/out of car	**Socially** 0 talking on telephone 0 entertaining guests at home 0 sitting in restaurant, movie 0 maintaining friends/relationships	

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Work History Form

PATIENT NAME:_________________________ TODAY'S DATE:____________________________
DATE OF INJURY:___________________Current Occupation Title:__________________________
Employer:________________________ Address of employer:_____________________________
Work phone:___________________ # Hours working per week:____________
Are you working now? Yes/no Missed time from work? yes/no
If missed time, dates out of work:____
Have you returned to work?: yes/no If yes, return date to work:___________________________
Job Description at time of injury:

____

Please describe your job in more detail (Circle # of hours of activity in your work day)

Sit	0-1	2-4	4-6	6-8
Stand	0-1	2-4	4-6	6-8
Walk	0-1	2-4	4-6	6-8
Lift	0-1	2-4	4-6	6-8
Push	0-1	2-4	4-6	6-8
Pull	0-1	2-4	4-6	6-8
Reach	0-1	2-4	4-6	6-8

Lifting in Pounds: CIRCLE

Up to 20	not at all	occasionally	frequently
20-40	not at all	occasionally	frequently
40-60	not at all	occasionally	frequently
60 and Up	not at all	occasionally	frequently

Repetitive Hand Actions: CIRCLE

	Simple Grasping	Fine Grasping	Fine Manipulation
Right Hand	Y / N	Y / N	Y / N
Left Hand	Y / N	Y / N	Y / N

Do you work more slowly since the injury?	Yes	No
Do you fatigue more easily?	Yes	No
Has your work production decreased?	Yes	No
Do you have difficulties coping with job pressures?	Yes	No
Do you have difficulty coping with time schedules and appointments?	Yes	No

If you have not returned to work because you cannot do these activities, **CHECK HERE** _____
If you have returned to work, have you had any difficulties or limitations since your injury with the categories mentioned above? Please explain:
____
____

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NEW PATIENT/RE-EVALUATION HEALTH QUESTIONNAIRE- page 1

Patient Name:______________________________ Date:______________________________

CHIEF COMPLAINT: WHAT BRINGS YOU TO OUR OFFICE TODAY?

Please describe:____

PAST MEDICAL HISTORY:

Name of Family Physician: __________________________ Date of Last Physical:_____________

HOSPITALIZATIONS/SURGERY in last 5 years? Yes/no

Please describe:____

ACCIDENTS IN LAST 5 YEARS? Motor vehicle, work related, fall, other: Yes/No

Please describe:____

MEDICATIONS: Currently taking any medications? Yes/no

Please describe:____

CURRENT MEDICAL CONDITIONS: Yes/No

Please describe:____

FAMILY HISTORY: Do you or anyone in your family have the following? Cancer, Diabetes, Heart Trouble, High Blood Pressure, Stroke, Multiple Sclerosis

Please describe:____

REVIEW OF ILLNESSES: Do you now or have you had any of the following illnesses? If yes, please circle:

Arthritis Asthma Sinus Trouble Hay Fever Allergies Tuberculosis Diabetes Epilepsy Thyroid Trouble High Blood Pressure Low Blood Pressure Heart Trouble Pacemaker HIV/ARC AIDS STD Ulcer Cancer Polio Rheumatic Fever Serious Injury Bone Fracture Dislocated Joints Spinal Disc Disease Multiple Sclerosis Scoliosis Mental/Emotional Difficulties Prostate Trouble Kidney Trouble Other

WE WILL NOT ACCEPT INDIVIDUALS FOR TREATMENT UNLESS THERE IS A MEDICAL NECESSITY AND WE FEEL CONFIDENT THAT WE CAN HELP THEM.

NEW PATIENT/RE-EVALUATION HEALTH QUESTIONNAIRE – PAGE 2

Patient Name:______________________________ Date: __________________________

REVIEW OF SYSTEMS: Are you presently suffering now, or within the past six months from any of the following?

1. General
0 Normal
0 Fatigue
0 Weakness
0 Fever
0 Loss of sleep
0 Chills
0 Weight change
0 Night sweats
0 Other

2. Skin
0 Normal
0 Rash
0 Redness
0 Itching
0 Dryness
0 Eczema
0 Hair Changes
0 Nail Changes
0 Bruise Easily
0 Other

3. Neurologic
0 Normal
0 Headache
0 Dizziness
0 Fainting
0 Convulsions
0 Nervousness
0 Other

4. Eyes

0 Normal	Left	Right
Vision Trouble	0	0
Pain	0	0
Discharge	0	0
Other		

5. Ears

0 Normal	Left	Right
Hearing Trouble	0	0
Ringing	0	0
Pain	0	0
Discharge	0	0
Other		

6. Nose
0 Normal
0 Pain
0 Bleeding
0 Sinus Problems
0 Infections
0 Absence of Smell
0 Other

7. Mouth/Throat
0 Normal
0 Sores
0 Bleeding
0 Enlarged Glands
0 Absence of Taste
0 Abnormal Taste
0 Tonsillitis
0 Other

8. Cardio-Vascular-Pulmonary (heart/lungs)
0 Normal
0 Coughing
0 Wheezing
0 Difficulty Breathing
0 Swollen Extremities
0 Blue Extremities
0 Varicosities
0 Murmur
0 Chest Pain
0 Palpitations
0 Other

9. Breasts
0 Normal
0 Lumps in Breasts
0 Redness/Itching
0 Pain
0 Dimpling
0 Discharge
0 Other

10. Gastrointestinal (stomach/digestion)
0 Normal
0 Decreased Appetite
0 Increased Appetite
0 Abdominal Pain
0 Hemorrhoids
0 Excess Gas
0 Vomiting
0 Diarrhea
0 Constipation
0 Other

11. Genitourinary
0 Normal
0 Inability To Hold Urine
0 Painful Urination
0 Frequent Urination
0 Bedwetting
0 Irregular Menstruation
0 Painful Menstruation
0 Abnormal Vaginal Bleeding
0 Impotence
0 Sterility
0 Prostate Problems
0 Other

12. Endocrine (metabolism)
0 Normal
0 Heat/Cold Intolerance
0 Sugar in Urine
0 Goiter
0 Tremor
0 Other

13. Psychologic
0 Normal
0 Anxiety
0 Depression
0 Memory Loss/Impairment
0 Phobias
0 Mood Swings
0 Other