MARY PACK ARTHRITIS PROGRAM
A part of the Vancouver Coastal Health Authority

Outpatient Day Program Health Assessment

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1. Name: ______________________________ **Date of Assessment:** __________________

Age: _________ ☐ Male ☐ Female
Culture/Ethnicity: ____
Language of Choice: ____
Chart # ________________ Family Dr. ______________________
Rheumatologist ____

2. RHEUMATOLOGIST=S SUMMARY

Diagnoses: 1st: ____
2nd: ____
3rd: ____
Impressions: ____
____

3. RHEUMATIC DISEASE ASSESSMENT

What concerns you most about your arthritis?
____
____

History of current illness:
Family History: ____

Onset & Progression: ____
____
____
____
____
____

Patient assessment of current disease severity ______________________________
____

Extra-articular and neurologic manifestations: ______________________________
____
____

Fatigue:
Has there been a change in your level of fatigue? ☐ Yes ☐ No
If yes, explain: ____

0 ____ **10**
No Fatigue Worse Fatigue

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.

- ☐ physiotherapy
- ☐ occupational therapy
- ☐ chiropractic treatments
- ☐ acupuncture
- ☐ massage therapy
- ☐ podiatry
- ☐ naturopathy
- ☐ 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:

- ☐ personal care
- ☐ sexual functioning
- ☐ homemaking
- ☐ leisure
- ☐ work

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______________	**Elbow**__________________
Hand__________________	(R) (L)	**Hand**__________________
Hip__________________		**Hip**__________________
Knee__________________		**Knee**__________________
Ankle/Hindfoot__________		**Ankle/Hindfoot**__________
Forefoot/MTP's__________	**Disease Activity** Tender(O) ________ 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: ____________________________

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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	**Goals**
1. ______________________	**1.** ______________________
2. ______________________	**2.** ______________________
3. ______________________	**3.** ______________________

Plan:

Estimated time on program: __________

PT: ______________________________

OT: ______________________________

MD: ______________________________

SW: ______________________________

RN: ______________________________