Date: _____

Neuroplasticity Rehabilitation Program

Constraint Induced Movement Therapy

Telephone Number: 205-934-0069

PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: _____

Address: _____ City _____ State _____ Zip code _____

Phone: ( ) _____ Email: _____

Gender: Date of Birth: _____ Age: _____ Last Grade Completed: _____ Occupation: _____

Check the program of interest: _____ Arm and Hand CI Therapy Program _____ Leg CI Therapy Program _____ Both

Do you give consent for the Neuroplasticity Rehabilitation Program to communicate with you by email for things such as appt reminders, invitations for video-calls, maps/ directions to the clinical location, etc? Yes No Comments: _____

CAREGIVER INFORMATION (can include a family member, friend, nurse, etc.)

Name: _____

Address: _____

Phone: ( ) _____ Email: _____

Relationship to Patient: _____ Phone: ( ) _____

Additional Contact Person: _____

TYPE OF INJURY

Date of Onset: _____ Side of Body Most Affected: _____

☐ Stroke Dominant Hand Prior to the event: ____Left __ Right

☐ Traumatic Brain Injury I am currently receiving:

☐ Multiple Sclerosis PT Yes _____ No _____

☐ Cerebral Palsy OT Yes _____ No _____

☐ Other _____ Speech Yes _____ No _____

I carry out a home exercise program ____ days per week for ____ minutes per day. Describe: _____

WALKING INFORMATION

Are you able to walk?	Yes	No
Do you use a wheelchair?	Yes	No
If you are able to walk, do you use a walker?	Yes	No
If you are able to walk, do you use a cane?	Yes	No
If you are able to walk, do you use a brace?	Yes	No

About how far can you walk at one time? _____

Do you walk at least 25 feet, 5 times a day? _____

About how many times each day do you walk? _____

Please return this completed information form to:
Neuroplasticity Rehabilitation Program
School of Health Professions -Depts of OT and PT
Attn: **Mary Bowman** SHPB 360Z
1720 2nd Avenue South Birmingham, AL 35294-1212

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MORE-AFFECTED HAND AND ARM INFORMATION

Please answer questions 1 through 3 with the weaker forearm resting on the arm of a chair, with the wrist bent downward and the hand hanging loosely over the front edge of the armrest.

1. Can you bend your wrist back without lifting your forearm? Yes No If yes, how much? _____
2. Can you open your hand? Yes No If yes, how much? _____
3. Can you move your thumb away from the palm of your hand? Yes No

For questions 4 through 7, your arm does not need to be in any special position.

4. Can you straighten your elbow? Yes No If yes, how much? _____
5. Can you touch your chin with your more-affected hand and return it to your lap? Yes No
6. Can you raise your arm at the shoulder? Yes No If yes, how much? _____
7. Can you pick up a tennis ball and release it? Yes No
8. Can you pick up a washcloth and release it? Yes No

MEDICATION INFORMATION

Please list all of your current medications and their intents.

MEDICATION	INTENT

Do you take oral medications for spasticity? Yes No If yes, are you on a steady dose? ___ What medication?_____

Have you received injections (Botox) to decrease your spasticity? Yes No If yes, when were your last injections & how did your body respond to these injections? Did you see benefit from these injections? Please describe. _____

HEALTH INFORMATION

Please mark if you have a history of any of the following conditions.

Heart Disease	Yes	No	Cancer	Yes	No
Hypertension	Yes	No	Depression	Yes	No
Pulmonary Disease	Yes	No	Diabetes	Yes	No
Thyroid Gland Disease	Yes	No	Head Injury or Surgery	Yes	No
Seizures	Yes	No	Expressive Aphasia	Yes	No
Allergies, Asthma	Yes	No	Receptive Aphasia	Yes	No
Anemia or Other Blood Problems	Yes	No	Other	Yes	No

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN. _____

PLEASE LIST THE NAME/CONTACT INFORMATION OF ANY PHYSICIAN AND/OR THERAPISTS YOU ARE SEEING.

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PAIN SCREEN

1. Do you have pain that interferes with your life or activities? If so, which word or words best describe the pattern of your pain? **Continuous, Periodic, Momentary**.

2. What kinds of things relieve your pain? _____

3. What kinds of things increase your pain? _____

4. How strong is your pain? People agree that the following 5 words represent pain of increasing intensity. They are:

1-mild 2-discomforting 3-distressing 4-horrible 5-excruciating

Please answer each of the following questions using the most appropriate word from the above selection.

1) Which word describes your pain right now? _____

2) Which word describes it as its worst? _____

3) Which word describes it when it is at its least? _____

YOUR GOALS FOR PARTICIPATION

Please list any goals you would like to accomplish during your treatment. Please be specific with your answers.

For example: " I would like to work outdoors without my cane." " I would like to be able to use utensils to cut food."