Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Mary Pack Arthritis Program

Patient Demographics Label

ICAP - Interdisciplinary Health Assessment

* *

TEAM INITIAL ASSESSMENT DATE:

Primary Rheumatologist:

Family Physician:

Ethnicity:

Gender:

REFERRAL HISTORY/DIAGNOSIS SUMMARY

____
____
____
____
____
____
____
____

CURRENT/MAIN CONCERNS

____
____
____
____

RELEVANT MEDICAL HISTORY (including surgeries, recent illnesses, hospitalizations)

____
____
____
____
____
____
____
____
____

Patient's Initials: _____

Family Medical History

☐ RA ☐SLE ☐Psoriasis ☐Osteoporosis ☐Multiple Sclerosis ☐IBD

Recent Bloodwork

Radiographs/Imaging (X-rays, CTs, MRIs, Bone scans, BMD, etc.)

MEDICATION SUMMARY (as per verified Medication Reconciliation)

Name	Dose	Route	Frequency	Notes

Vitamins, minerals, herbals, or recreational drug products? ☐Yes ☐No

Comments:

_____

_____

_____

_____

Allergies and Reactions (as per Allergy Documentation Form)

Allergen **Reaction Type**

_____

_____

_____

Recent Vaccination History

- ☐**Influenza. When:**
- ☐**Prevnar 13. When:**
- ☐**Pneumovax. When:**
- ☐**Shingles. Which one? When?**
- ☐**Tetanus, Diptheria, Pertussis. When?**
- ☐**TB skin test. When? Result?**
- ☐**Others:**

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Mary Pack Arthritis Program

Patient's Initials: _____

INTAKE ADMISSION ASSESSMENT

INTAKE VITALS

BP Left Arm:

SpO2:

BP Right Arm:

Height:

Heart Rate:

Weight:

Temperature:

BMI:

PAIN

Is it a problem? ☐Yes ☐ No

Areas Involved	Pain Scale
	/10
	/10
	/10

Please describe your pain:

_____

_____

_____

_____

_____

How do you manage your pain?

_____

_____

_____

_____

_____

Patient's Initials: _____

FATIGUE

Has there been a change in level of fatigue? ☐ No ☐Yes, If yes: ☐Improved ☐Worsened

Level of fatigue over past week: /10

1. **What time of day do you start to feel tired?**
2. **How do you manage your fatigue?**

SLEEP HYGIENE

Time to bed: **Time out of bed:** **# of hours of sleep:**

1. **Problems falling asleep:** ☐ Yes ☐ No **Explain:**
2. **Night awakenings:** ☐ Yes ☐ No **How often:**
3. **Sleep aides/techniques**: ☐ Yes ☐ No **Explain:**
4. **Naps during the day:** ☐ Yes ☐ No **How often:**

MORNING STIFFNESS

Is morning stiffness present? ☐ Yes ☐ No

1. **If yes, which parts of your body?**
2. **If yes, how long does it last?**
3. **What makes the stiffness better?**

PHYSICAL / FUNCTIONAL ABILITY

Hand Dominance: ☐ Right ☐ Left

Indicate Areas of Concern:

☐ Personal care ☐ Housework ☐ Leisure
☐ Meal preparation ☐ Professional work ☐ Family/Relationships

Explain:

_____
_____
_____
_____
_____

TRANSPORATION / MOBILITY

Mobility Aids ☐Yes ☐ No **Equipment use:**

Walking/Sitting Tolerance:

Transportation Method:

PREVIOUS TREATMENT MODALITIES

☐ Physiotherapy	☐ Massage therapy	☐ Traditional Chinese Medicine
☐ Occupational therapy	☐ Podiatry	☐ Acupuncture
☐ Chiropractic treatments	☐ Naturopathy	☐ Others:

Comments:

_____

_____

_____

HEALTH HABITS

1. **Alcohol Intake (past and present):**

2. **Cigarette Smoking/Vaping History** ☐Yes ☐No
   a. **How much:**
   b. **Year started:**
   c. **Year quit:**

3. **Activity Level**
   a. On average, how many days a week do you do physical activity or exercise where your heart beats faster and your breathing is harder than normal (such as brisk walk)? _____ **days/week.**
   b. On average, how many *total minutes* of physical activity/exercise do you do on those days? _____**mins.**
   c. On average, how many awake hours in a day do you spend sitting or lying still (e.g. watching TV, using computer, reading)? _____**hours/day.**

Patient's Initials: _____

SOCIAL HISTORY

Occupation:

_____

_____

Marital Status:

_____

_____

Living Situation:

_____

_____

Support System:

_____

_____

FINANCIAL SITUATION

1. **Source of current financial income:**
2. **Extended health benefits:**
3. **Funding:** ☐ Persons with Disability ☐ First Nations Health
   ☐ Others:

PSYCHOSOCIAL: STRESSORS & COPING STRATEGIES

1. **What are your current sources of stress?**
2. **How do you normally manage your stress?**
   ☐ Friends ☐ Family ☐ Clubs, organizations ☐Counselling support

   Comments:

   _____

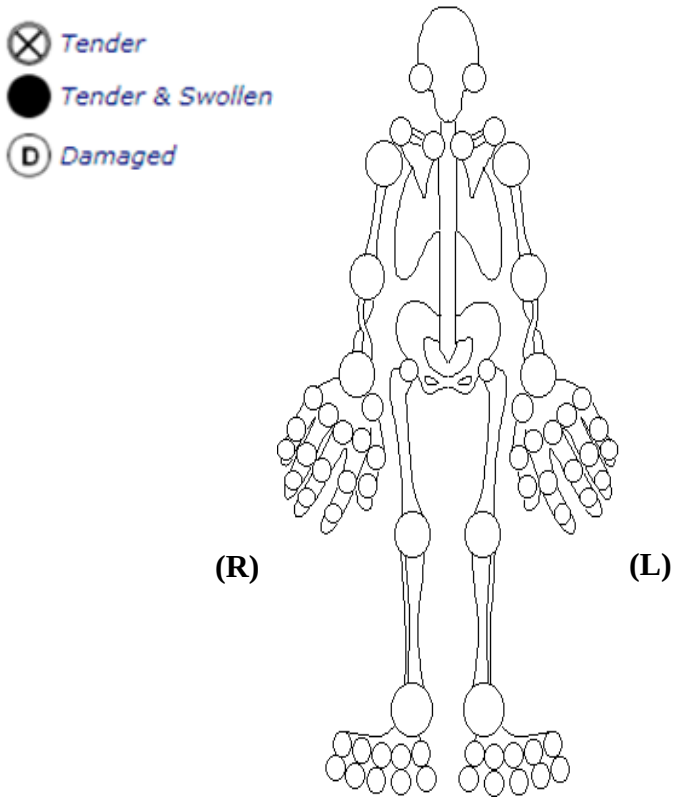
   _____

   _____

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Mary Pack Arthritis Program

NURSING & PHYSICIAN PHYSICAL EXAMINATION



TJS: ***SJC:*** ***Damaged:***

Systems Review:

Cardiac:

Respiratory:

Abdominal:

Lymph Nodes:

GENERAL IMPRESSION/SUMMARY

Form completed by: _____ Signature: _____ Designation_____ Date_____

MD Name: _____ MD Signature: _____

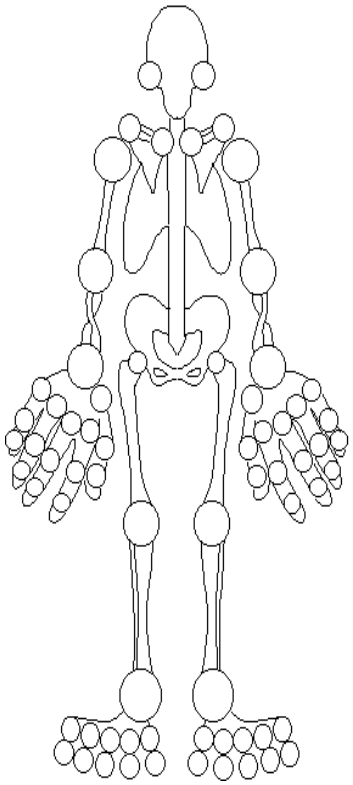
Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Mary Pack Arthritis Program

Patient's Initials: _____

Inflammatory Joint Assessment (Physiotherapy)

Patient's Name: _____ Date: _____

Shoulder(SC, AC) _____ _____ _____ _____ _____ **Elbow**_____ _____ _____ _____ **Hand**_____ _____ _____ _____ _____ _____ _____ **Hip**_____ _____ _____ _____ **Knee**_____ _____ _____ _____ _____ _____ **Ankle/Hindfoot**_____ _____ _____ _____ _____ **Forefoot/MTP's**_____ _____ _____	**C/SPINE** _____ **TMJ** Opening_____ (R) (L)  **Disease Activity** Tender (X) _____ Swollen (●) _____ Damaged (D) _____	**Shoulder**(SC, AC)_____ _____ _____ _____ _____ **Elbow**_____ _____ _____ _____ **Hand**_____ _____ _____ _____ _____ _____ _____ **Hip**_____ _____ _____ _____ **Knee**_____ _____ _____ _____ _____ _____ **Ankle/Hindfoot**_____ _____ _____ _____ _____ **Forefoot/MTP's**_____ _____ _____

Form completed by: _____ Signature: _____ Designation_____ Date_____

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Mary Pack Arthritis Program

Patient's Initials: _____

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	_____	_____	_____	_____	

Form completed by: _____ Signature: _____ Designation_____ Date_____

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Mary Pack Arthritis Program

Occupational Therapy Assessment

Patient's Name: _____ Date: _____

Musculo-Skeletal Review	Impact on Function/Occupation
T.M.J.	
Cervical Spine	
Shoulder	
Elbow	
Wrist	
Hands	
Back	
Hips	
Knees	
Ankles	
Feet	

Form completed by: _____ Signature: _____ Designation_____ Date_____