Initial Assessment for Electrical Stimulation of the Upper Limb

Name…… DOB…… Hospital no. …… Tel. no.	Centre: Assessment date: Referring GP/Consultant:
Address/label:	Receiving Physio/OT: Y/N Details:
History of Present Condition - date of onset	Affected side L/R independent in transfers & gait for treatment? Y/N (if no, complete manual handling form)

Medical History

Epilepsy Y/N Controlled Y/N Frequency of fits……...

Cardiac problems Y/N Pacemaker Y/N

……

Skin problems Y/N

……

Sensation problems Y/N

……

Previous trauma/surgery Y/N

……

Previous or present malignancy Y/N

……

Medication

……

Use of splints /Botulinum toxin

……

Pregnancy Y/N……...

Social History

Lives alone/with family……..

Assistance with ADL Y/N….....

Works Y/N ……

Drives Y/N……..

Hobbies……..

Clinician ……. Print……. Designation……..

Upper limb Assessment

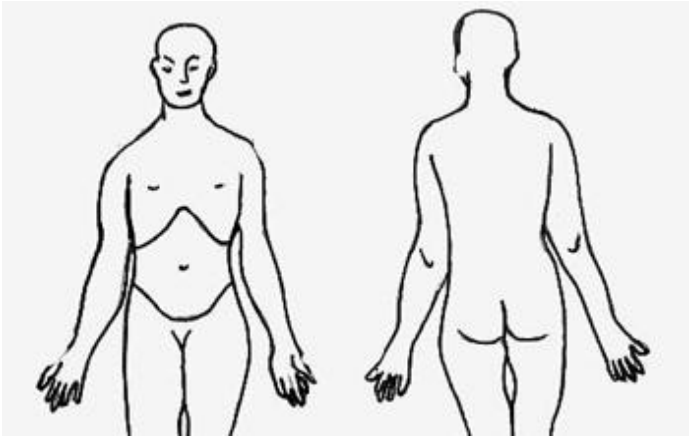
Name: **Number/DOB.** **Date:**

Affected side R/L

Assessed side R/L

Dominant hand R/L

Indicate on diagrams -
Shoulder subluxation /pain
(no.of finger widths/site, score/10)



Sensory problems

Position of patient (lying / sitting)

Joint	Passive ROM	MRC Scale	Ashworth Scale
Shoulder girdle			
Elevation			Elevators
Depression			Depressors
Protraction			Protractors
Retraction			Retractors
Shoulder joint			
Flexion			Flexors
Extension			Extensors
Abduction			Abductors
Adduction			Adductors
Int. rotation			Int. rotators
Ext. rotation			Ext. rotators
Elbow			
Flexion			Flexors
Extension			Extensors
Pronation			Pronators
Supination			Supinators
Wrist			
Flexion			Flexors
Extension			Extensors
Radial deviation			Radial deviators
Ulna deviation			Ulna deviators

Clinician…….. Print……. Designation……

Hand Assessment

Name Number/d.o.b. Date

Fingers
(active and passive ROM, tone)

Thumb
(active & passive ROM, tone)

Whole limb function	
List any functional tasks achieved & score as below: None – state none Uses mostly compensatory movement (1) Uses minimum compensation (2) Normal movement (3)	
Hand function	
Consider: **Ability to grip & release.** (define type of grip if appropriate power, pinch, pincer, lateral) **Selectivity of movement.** (ability to pick up & manipulate objects)	

Problem Summary

1.

2.

3.

4.

Clinician ……. Print…….. Designation…….

Upper Limb Assessment

Name Number/d.o.b. Date

Functional / Non functional (please circle). If functional refer to functional clinic.

Agreed Treatment Goals

1.
2.
3.
4.

Outcome Measure(s) to be used

Stimulator used – Microstim 2, 04Channel

Site stimulated	Electrodes used MS2	Comments
Trapezius (middle, lower fibres)		
Supraspinatus		
Deltoid (anterior, middle, posterior)		
Triceps		
Biceps		
Forearm extensors		
Forearm flexors		
Lumbricals		
Thumb abduction		
Thenar eminence		
Other		

Clinician …….. Print…….. Designation…….....