Vancouver CoastalHealth
Promoting wellness. Ensuring care

OASIS Pt ID: _____

This information will assist the OASIS Team with your assessment.
Please bring this completed form to your assessment appointment. Thank you.

OASIS Assessment Tool

Client Name: _____

Birthdate (yy/mm/dd): _____

Family Dr.: _____

Appt Date: _____

During your appointment we will have time to assess 1-2 joints. We can book future appointments if needed.

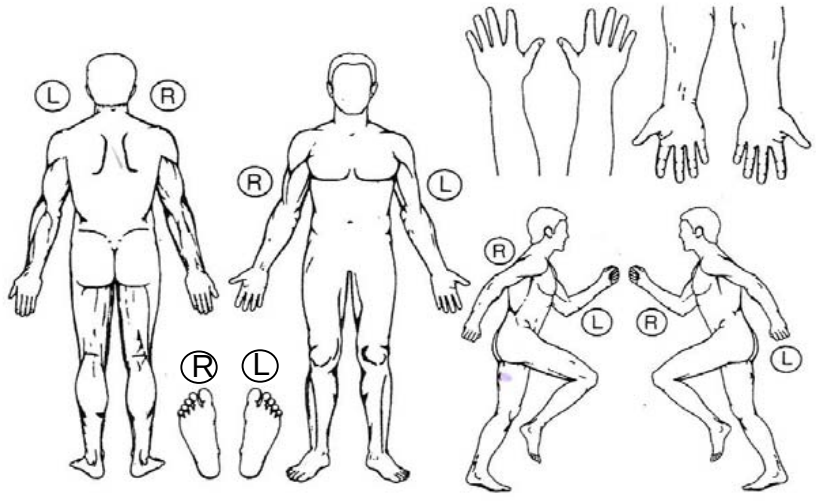
SECTION 1 - All Clients to Complete

Client Goals

Please indicate what your goals are by checking the appropriate boxes (check all that apply).

1. ☐ To manage my pain
2. ☐ To learn if I need surgery (joint replacement)
3. ☐ To learn how to manage my daily activities at home/work
4. ☐ To improve my ability to be active (specify activities): _____
5. ☐ To manage:
   - ☐ Weight problems
   - ☐ Medication
   - ☐ Healthy Eating
   - ☐ Sleep disturbances
   - ☐ Stress / Anxiety / Depression
6. ☐ To get my home set up for safety and independence
7. ☐ Other (specify): _____

Pain Inventory



On the diagram, shade in all areas where you feel pain.

Which joint bothers you the most or which causes you the most concern?

_____

When did the pain start?

_____

Over the past 6 months, has your pain become worse **Yes / No**

_____

On a scale of 0 (no pain) to 10 (worst pain imaginable):

1. Rate your pain when resting: _____
2. Rate your worst pain within the past 6 months: _____.

SECTION 2

Pain Inventory (Continued)

1. The following questions concern the amount of joint stiffness (not pain) you are currently experiencing. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints. *(Please mark your answers with an "X")*

	None	Mild	Moderate	Severe	Extreme
How severe is your **stiffness** after first wakening in the morning?	☐	☐	☐	☐	☐
How severe is your **stiffness** after sitting, lying or resting later in the day?	☐	☐	☐	☐	☐

2. Are there activities that make your pain worse? Yes / No If yes, what are they?

_____

_____

_____

3. The following questions are only to be answered if you have osteoarthritis in your hips, feet, ankles, and/or knees. For each situation, please enter the amount of pain recently experienced.

How much **pain** do you have:	None	Mild	Moderate	Severe	Extreme
Walking on a flat surface?	☐	☐	☐	☐	☐
Going up or down stairs?	☐	☐	☐	☐	☐
At night while in bed?	☐	☐	☐	☐	☐
Sitting or lying?	☐	☐	☐	☐	☐
Standing upright?	☐	☐	☐	☐	☐

Functional Limitations

Do you have any problems in day to day activities, such as taking care of yourself or working? Y / N If yes, please list these problems and tell us what you are unable to do.

_____

_____

_____

_____

_____

Is there anything else you would like us to know or to have us focus on?

_____

SECTION 2

Pain Management

What have you tried in the past to relieve your pain? Did it work?

_____

_____

List all medications & supplements you are taking or have tried. Tell us how much you take and whether it works in making your symptoms better.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical & Health History

Please list all other medical conditions & any previous surgeries:

_____

_____

_____

_____

_____

Please list all allergies & the nature of your reaction:

_____