

**ASSESSMENT FORM – HAND****AO neutral-0 method**

<b>Patient:</b>	<b>Date of birth:</b>
Date:	Tel.:
Diagnosis:	
Date of surgery:	Therapist:
School/profession:	Doctor:
Dominance: <input type="checkbox"/> right <input type="checkbox"/> left	
Special notes:	
Aims of intervention:	

Measurement		Date:					Date:				
Wrist ex/flex	r.	/	/				/	/			
	l.	/	/				/	/			
Sup/pro	r.	/	/				/	/			
	l.	/	/				/	/			
Ulnar/rad. dev.	r.	/	/				/	/			
	l.	/	/				/	/			
Fingers/thumb		I	II	III	IV	V	I	II	III	IV	V
Fingers ex/flex											
MCP	r.										
MCP	l.										
PIP/IP	r.										
PIP/IP	l.										
DIP	r.										
DIP	l.										
Power grip – distance fingertip-palm	r.										
	l.										
Hook grip	r.										
	l.										
Thumb abduction		r.		l.			r.		l.		
Opposition		r.		l.			r.		l.		
Peg board		r.		l.			r.		l.		
		sec.					sec.				
Pain											
Sensibility											
Other (blisters, scars, trophic changes)											