CASE STUDY FORM

PLEASE PRINT CLEARLY.

Name ____
Last First MI Degree

Complete the contact information below, only if it has changed.

Work Address ____
Street Address City State ZIP

Work Phone Number ______________________ E-mail Address ______________________________

Please fill out the following information, and email the completed form to info@NeuroRehabResource.org; or fax to 973-758-0052.

Preceptor Name ____
Last First MI Degree

Patient information: Age_______ **Race** _______ **Height** _______ **Weight** ________

Patient number __________________

Current medications (Please include prescription and over-the-counter medications and herbal supplements)

Medication name	Reason for taking	Dosage	How long have you been taking this?

Presenting complaint ____

____

Medical history (Please include relevant conditions and comorbidities.)

Condition	Yes	No	Date diagnosed	If yes, please specify and describe.
Diabetes				
Hypertension				
Hyperlipidemia				
Heart disease				
Thyroid disease				
Autoimmune disorders				
Degenerative diseases				
Neuromuscular disorders				
Fixed contractures				

Psychosocial history (Please include history of depression and how spasticity affects quality of life.) ______________________________

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____

Results of physical examination____

____

____

Level of impairment caused by spasticity ____

____

____

Method(s) used to evaluate level of spasticity-related impairment ____

____

____

Is there spasticity-related pain? ❑ **Yes** ❑ **No**

Laboratory tests

Test	Date	Results

Caregiver interview (ie, how spasticity affects quality of life and care) ____

____

____

Diagnosis ____

____

____

Treatment plan (ie, physical therapy, oral medications, injectable medications, surgery)

List all therapies considered.	Therapy chosen (√)	Reason for recommending or rejecting.	Who made the decision to select or reject therapy? (clinician, patient, caregiver, etc)

Treatment goals ____

____

____

Date of follow-up visit ______________________

List each therapy tried.	Was treatment successful? Please circle one.	Continue or stop treatment? Please circle one.	List any adverse effects experienced from treatment.
	Yes No	Continue Stop	
	Yes No	Continue Stop	
	Yes No	Continue Stop	
	Yes No	Continue Stop	
	Yes No	Continue Stop	

Please describe improvement in spasticity-related symptoms and method(s) used to measure improvement. ___________________________

____

____

If present at initial examination, did spasticity-related pain improve? ______________________

Other issues discussed at follow-up visit ____

____

Comments/conclusions ____

____

____

Signature ____ **Date** ________________________