How to Apply for a Constraint-Induced Movement Therapy (CIMT) Program

Constraint-Induced Movement Therapy (CI Therapy, or CIMT): Two Programs
There are two programs offered it the Taub Therapy Clinic for CIMT. You may apply for one or both of these programs although treatment for these programs is not combined but given three months apart so that each patient has a chance to focus on using a specific limb in treatment. These two programs are as follows:

• Arm/ Hand CI Therapy Program
• Leg/ Walking CI Therapy Program

Who is a candidate for Constraint-Induced Movement Therapy (CI therapy, or CIMT)?
Most candidates for CI therapy have already completed their traditional rehabilitation. However, many continue to suffer from the chronic effects of a stroke, traumatic brain injury, or other neurological injury. For appropriate candidates, CI therapy has been found to be effective no matter how long ago the stroke or injury occurred. CI therapy has specific requirements for acceptance into the Arm/ Hand CI Therapy Program and / or the Leg/ Walking CI Therapy Program. Your application form and video are reviewed by our therapists to see if you or your loved one meets criteria to receive treatment at this clinic.

What kind of time commitment is involved?
As the patient, you will play an integral role in your own success at the Taub Therapy Clinic. One of the reasons CI therapy is more effective than other therapy programs is because of its intensity. Depending upon each patient’s condition, CI therapy may consist of sessions 3 ½ to 4 hours each day, 5 days per week for 2 to 3 weeks. Patients must also complete tasks and/or exercises independently or with the assistance of companion in the evenings and on weekends. After completing their CI therapy program, patients are given an individualized program to follow at home. The patient is also asked to complete four self-evaluations to help the clinic track progress and to make recommendations for improving the home program.

How do I apply?
Candidates must submit a written application to the Taub Therapy Clinic. There are two ways to send your application to the Taub Therapy Clinic including:

1. Download and print the pdf version of the application form and return it with the required videos by email Taubclinic@uabmc.edu, fax (205)975-9700, or by mail (address below).
2. Request an application form by calling 1-866-554-TAUB (8282) and return it with the required videos by email Taubclinic@uabmc.edu, fax (205)975-9700, or by mail (address below).

Mailing Address:
Taub Therapy Clinic
Spain Rehabilitation Center
Room R385
1717 6th Avenue South
Birmingham, AL  35249
PATIENT INFORMATION FORM
WITH INSTRUCTION FOR FILMING

*Please visit our website to find instructions for filming the movement of your arm and hand and for filming walking activities. Return the video with your completed patient information form to the address provided.*

PATIENT INFORMATION

Name: _____________________________
Address: ___________________________
City ____________________ State ______ Zipcode ________
Phone: (____) __________ Email: _______________________
Gender: Male Female Date of Birth: _________________ Age ________
I am interested in: (Check one) _______ Arm and Hand Program _______ Leg Program _______ Both
Last Grade Completed ___________________________ Occupation ________________________

CAREGIVER INFORMATION*

*caregiver other than a physician (could include a family member, friend, nurse, etc.)

Name: _____________________________
Address: ___________________________
Phone: (____) __________ Email: _______________________
Relationship to Patient: ___________________________
Additional Contact Person: ______________________ Phone: (____) ________________________

TYPE OF INJURY

Date of Injury: _______________ Side of Body Most Affected: ___________________________
☐ Stroke Dominant Hand Prior to the event: Left _____ Right _____
☐ Traumatic Brain Injury I am currently receiving:
☐ Broken Hip PT Yes _____ No ______
☐ Spinal Cord Injury OT Yes _____ No ______
☐ Other Speech Yes _____ No ______
I carry out a home exercise program _____ days per week for _____ minutes per day. Describe: ___________________________

WALKING INFORMATION

Are you able to walk? Yes No
Do you use a wheelchair? Yes No
If you are able to walk, do you use a walker? Yes No
If you are able to walk, do you use a cane? Yes No
If you are able to walk, do you use a brace? Yes No
About how far can you walk at one time? ___________________________
Do you walk at least 25 feet, 5 times a day? ___________________________
About how many times each day do you walk? ___________________________
TAUB THERAPY CLINIC
Constraint Induced Movement Therapy

AFFECTED HAND AND ARM INFORMATION

Please answer questions 1 through 3 with the weaker forearm resting on the arm of a chair, with the wrist bent downward and the hand hanging loosely over the front edge of the armrest.

1. Can you bend your wrist back without lifting your forearm? Yes No If yes, how much?
2. Can you open your hand? Yes No If yes, how much?
3. Can you move your thumb away from the palm of your hand? Yes No

For questions 4 through 7, your arm does not need to be in any special position.

4. Can you straighten your elbow? Yes No If yes, how much?
5. Can you touch your chin with your more-affected hand and return it to your lap? Yes No
6. Can you raise your arm at the shoulder? Yes No If yes, how much?
7. Can you pick up a tennis ball and release it? Yes No
8. Can you pick up a washcloth and release it? Yes No

MEDICATION INFORMATION

Please list all of your current medications and their intents.

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Do you take oral medications for spasticity? Yes No If yes, are you on a steady dose? ___ What medication?___________

Have you received injections (Botox) to decrease your spasticity? Yes No If yes, when were your last injections & how did your body respond to these injections? Did you see benefit from these injections? Please describe. ________________

HEALTH INFORMATION

Please mark if you have a history of any of the following conditions.

Heart Disease Yes No Cancer Yes No
Hypertension Yes No Depression Yes No
Pulmonary Disease Yes No Diabetes Yes No
Thyroid Gland Disease Yes No Head Injury or Surgery Yes No
Seizures Yes No Expressive Aphasia Yes No
Allergies, Asthma Yes No Receptive Aphasia Yes No
Anemia or Other Blood Problems Yes No Other Yes No

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN. ________________

PLEASE LIST THE NAME/CONTACT INFORMATION OF ANY PHYSICIAN AND/OR THERAPISTS YOU ARE SEEING.
PAIN SCREEN

1. Do you have pain that interferes with your life or activities? If so, which word or words best describe the pattern of your pain?
   Continuous, Periodic, Momentary.

2. What kinds of things relieve your pain?

3. What kinds of things increase your pain?

4. How strong is your pain? People agree that the following 5 words represent pain of increasing intensity. They are:

   1-mild  2-discomforting  3-distressing  4-horrible  5-excruciating

   Please answer each of the following questions using the most appropriate word from the above selection.

   1) Which word describes your pain right now?

   2) Which word describes it as its worst?

   3) Which word describes it when it is at its least?

YOUR GOALS FOR PARTICIPATION

Please list any goals you would like to accomplish during your treatment. Please be specific with your answers.

For example: "I would like to work outdoors without my cane."" I would like to be able to use utensils to cut food."

Please return this completed information form to:
UAB Taub Therapy Clinic • Spain Rehabilitation Center • R385 • 1717 6th Avenue South • Birmingham, AL 35249
Clinic Email: taubclinic@uabmc.edu
VIDEO INSTRUCTIONS

Dear Interested Patient:

In addition to sending your patient information form, we also ask you send in a video. The video will allow our staff to evaluate your current movement ability with your involved upper extremity and your ability to walk.

Listed below are the items to be included in the video. If you are interested in both the upper and lower extremity programs, please include the movement of your involved upper extremity, as well as video of yourself walking.

UPPER EXTREMITY

If you have difficulty performing the requested movement or are unable to complete the task as requested, please film your attempts of the movement or do as much of the task as possible.

Perform or attempt each individual movement **three** times within one minute unless otherwise specified.

**Camera angle:**

- Items 1-6 position the camera opposite your affected side.
  - Items 1-5 zoom in on your hand movement.
- Items 7-10 position the camera in front of you.
  - Items 7-10 zoom out to include your entire upper body during these tasks.

**Arm and Hand position**

*Items 1-2 should be performed while seated in a chair with armrests:*

- Place your involved forearm on the armrest of a chair
- Wrist bent downward and your hand hanging loosely over the front edge of the armrest.
  1) Bend your wrist back without lifting your forearm from the armrest.
  2) Open and close your hand as if making a fist
Items 3-6 should be performed while seated, with your involved forearm and hand should be resting on a table:

3) Move your thumb away from the palm of your hand.
4) Pick up a tennis ball from the table and release it.
5) Pick up a washcloth from the table and release it.
6) Place your hand on the table in front of you by moving it from your lap without assistance.

Items 7-10 may be performed in sitting or standing:

7) Bend and straighten your elbow as far as you can.
8) Touch your chin with your hand and return it to your lap.
9) Keeping your elbow as straight as possible, raise your arm in front of you as high as you can.
10) With your arm at your side, lift your arm away from your body as far as you can (similar to lifting arm overhead during a jumping jack).

LOWER EXTREMITY

Please include a video of yourself walking at least 25 feet. If you require assistance of another person to walk, use a brace, or walk with an assistive device please include this in the video.

1) Include camera views of yourself walk from the following views:
   a. Front view
   b. Rear view
   c. Side view

2) Include video of walking to a chair, sitting down, and then standing back up from the chair.

Please mail your video to the following address:

Taub Therapy Clinic
Spain Rehabilitation Center
Room 385
1717 6th Avenue South
Birmingham, AL 35249

Please send us a DVD, attach video files to an email, or upload videos to Snapfish at www.snapfish.com. Should you send videos by email, send them to the clinic’s email address at taubclinic@uabmc.edu. Should you upload videos to Snapfish, please invite the Taub Clinic at our email address, to view the videos.

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