Interlocking Fingers Test

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Client Information

Name:

Date of Birth:

Gender:

Address:

Phone Number:

Email Address:

Date of Consultation:

Description of the patient's condition

Right Hand:

Degree of Interlocking:

- ◯ Complete
- ◯ Partial
- ◯ None

Gaps/Limitations: (If any)

Left Hand:

Degree of Interlocking:

- ◯ Complete
- ◯ Partial
- ◯ None

Gaps/Limitations: (If any)

Interpretation:

Recommendation:

Notes: