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COMPREHENSIVE PHYSICAL THERAPY
PATIENT INFORMATION

☐ New Patient ☐ Return Patient Email: ______________________

Patient Name: ______________________

Address: ______________________
Street # or PO Box City State Zip Code

Date of Birth: ____________ Age: ______ ☐ Male ☐ Female SS#: ____________

Home Phone: ______________ Work or Cell Phone: ______________

Patient Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES FOR ANY REASON? ☐ YES ☐ NO
IS THIS INJURY THE RESULT OF A WORK RELATED ACCIDENT?: ☐ YES ☐ NO
IS THIS INJURY THE RESULT OF AN AUTO RELATED ACCIDENT?: ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US?

☐ Newspaper ☐ Past Patient/Friend ☐ Medical Doctor ☐ Website
☐ Yellow Pages ☐Other ______________________

DOCTOR/EMERGENCY CONTACT INFORMATION: (required)

Referring Physician: ______________ Primary Care Physician: ______________

Date Last Seen: ______________ Date Last Seen: ______________

Emergency Contact: ______________________

Relationship: ______________ Phone Number: ______________

PRIVATE INSURANCE/FINANCIAL RESPONSIBILITY INFORMATION: (required)

Person Financially Responsible: ______________ Phone: ____________

Address: ______________________

Relationship to Patient: ______________________

Primary Insurance: ______________ **Secondary Insurance:** ______________

Policy#: ______________ Policy #: ______________

Group #: ______________ Group #: ______________

Is the Patient the Subscriber? ☐ Yes ☐ No **Is the Patient the Subscriber?: ☐ Yes ☐ No**

IF NO PLEASE COMPLETE SECTION BELOW

Subscriber Name: ______________ **Subscriber Name:** ______________

SS#: ______________ SS#: ______________

Date of Birth: ______________ Date of Birth: ______________

Relationship to Patient: ______________ Relationship to Patient: ______________

- CONTINUED -
PLEASE COMPLETE SECOND PAGE

ILLNESS OR ONSET OF PAIN INFORMATION: (required)

□ ILLNESS □ INJURY Date of Injury/Onset of Symptoms: ______________________________

What body part is involved: ____ □ Left □ Right

Injury Occurred: □ Home □ Employment* □ School* □ Recreation* □ Pedestrian* □ MVA/Auto*

□ Other – Briefly explain: ____

***If this is a Workers Comp/Liability/Auto Claim - Please Complete Section Below**

Name of Workers Compensation/Liability/Auto Insurance: ____

State that incident occurred in: ________________________ Claim #: ___________________________________

Insurance Adjusters Name: ____

Phone Number: ___________________________________ Extension Number: ______________________________

Has an Attorney been obtained: □ Yes □ No – If yes please complete below

Attorney Name: ____ Phone: ____________________________

ADDITIONAL INFORMATION: (required)

Employer: ______________________________________ Phone: ______________________ □ Retired

Address: ____ Job Description: ____________________________

Are you a student? □ Yes □ No □ Full Time □ Part Time

MEDICAL HISTORY

Please check any medical conditions that we should be aware of:

____ High Blood Pressure ____ Scoliosis/Back Disorder ____ Heart Attack/Heart Problems

____ Diabetes ____ Lung Disorders ____ Blood Disorders

____ Cancer ____ Ulcer/Digestive ____ Arthritis

____ Metal Implants ____ Pacemaker ____ Seizure Disorder

____ Hepatitis C ____ Tuberculosis ____ Vertigo

Are you Pregnant? □ yes □ no

Any Other Conditions/Concerns that we should be aware of?: ____

____

Surgeries and Surgical Dates: ____

____

Medication List Attached: Please complete

ALLERGIES: ____

Have you had any diagnostic testing performed related to your current injury?

□ MRI □ X-ray □ CT Scan □ EMG □ None □ Other: ____

To the best of my knowledge, the information that I have given is complete and true.

Patient/Guardian Signature: ____ **Date:** ______________

Therapist Signature: ____ **Date:** ______________

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DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\left(\frac{\text{sum of n responses}}{n}\right) - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may not be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including home-making if that is your main work role).

Please indicate what your job/work is:______________________________

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:____________________

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.

An optional module score may not be calculated if there are any missing items.

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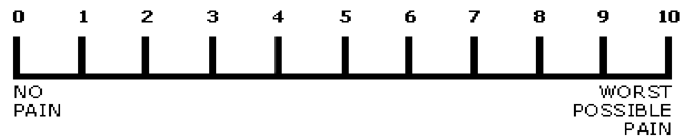
How would you describe your pain today?



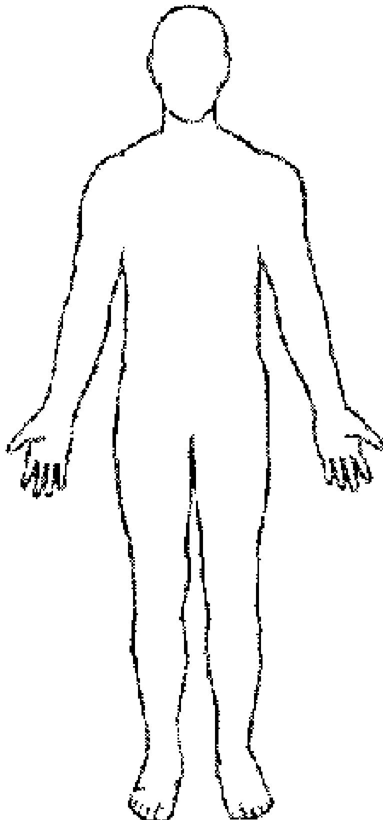
Using the 0 to 10 pain scale, please rate your **least pain** in the past 24 hours: ______

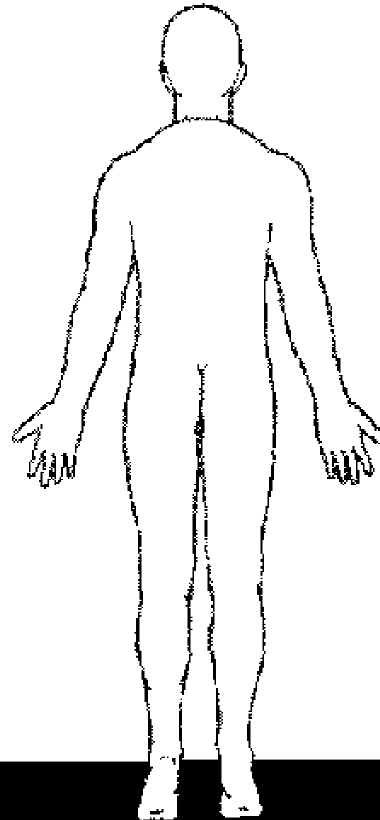
Using the 0 to 10 pain scale, please rate your **worst pain** in the past 24 hours: ______

Are your symptoms – **worse – staying the same – better –** since the onset of symptoms?

Using the key provided please mark on the outlines below where you are experiencing any of the following symptoms:

A – Achiness N – Numbness T – Tingling S- Stiffness H – Throbbing Pain
P – General Painful Feeling





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Patient Name: ____ Date: ____________