Clifton-Fine Hospital

Physical Therapy Patient Information

Name: _____ DOB: _____ Date: _____

1. Please describe your reason for coming to therapy and what symptoms you are currently having: _____
   _____
2. When did your problem begin? _____
3. Describe how your problem began. _____
   _____
4. How much of the time do you have symptoms?
   [ ]Constant(76-100%) [ ]Occasional(26-50%)
   [ ]Frequent(51-75%) [ ]Intermittent(25% or less)
5. Indicate the intensity of your pain at rest. (circle the appropriate number)
   (No Pain) 1 2 3 4 5 6 7 8 9 10 (severe Pain)
6. Indicate the intensity of your pain with movement. (circle the appropriate number)
   (No Pain) 1 2 3 4 5 6 7 8 9 10 (severe Pain)
7. What makes your symptoms worse? _____
   _____
8. What makes your symptoms better? _____
   _____
9. Have you had this problem before? _____
10. Medical History (check all that apply)

[ ] Heart Disease	[ ]Cancer	[ ]Osteoporosis
[ ]Pacemaker	[ ]High blood pressure	[ ]Osteoarthritis
[ ]High cholesterol	[ ]Lung Disease	[ ]Diabetes
[ ]Pain at night	[ ]Headaches	[ ]Low Back Pain
[ ]Cough	[ ]Dizziness/blackouts	[ ]Loss of balance
[ ]Nausea/vomiting	[ ]Weight loss/Gain	[ ]Current Pregnancy
[ ]Chest pain	[ ]Fibromyalgia	[ ]Coordination problems
[ ]Urinary Problems	[ ]Bowel problems	[ ]Vision Problems
[ ] Hearing Problems	[ ]GERD(Reflux)	[ ]Loss of Appetite
[ ]Fever/Chills/sweats	[ ]Shortness of Breath	[ ]Heart Palpitations
[ ]Weakness in arms or legs	[ ]History of smoking	[ ]Stroke
[ ]Asthma	[ ]Rheumatoid Arthritis	[ ] other _____

   Please list surgeries: _____
11. Medications: _____
    _____
12. Allergies[ ] None or list (including latex) _____
13. Occupation(including housewife,student,retired) _____
14. What are your goals for physical therapy? _____
    _____
15. Have you fallen within the last 6 months? [ ]Yes [ ]No If so, how many times? _____

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

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

Rehabilitation Services
Informed Consent

Conditions and Consent for Physical Therapy.

Informed Consent for Treatment I understand that the term 'informed consent' means that the potential risks, benefits, and alternatives of physical therapy have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Cooperation with Treatment I understand that in order for Physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home Physical Therapy exercise program developed for me. If I have trouble with any part of my treatment program, I will discuss itm with my Physical Therapist.

Cancellation Policy I understand that to successfully achieve the goals of treatment established by myself and my physical therapist it is essential for consistent attendance as outlined in my plan of care. I understand that three (3) or more no shows could result in my discharge from therapy.

Financial and Insurance Responsibilities I understand that it is my responsibility to call my insurance company ahead of time to obtain pre-authorization that may be necessary for PT, and to obtain verification of my outpatient physical therapy benefits.

Potential Risk of PT I understand that during my initial evaluation or following treatment sessions I may experience an increase in current pain or aggravate my current condition. I agree to discuss any of aggravation of my current symptoms with my therapist if they last longer than 24 hours.

I have read the above and I consent to Physical Therapy evaluation and therapy treatments at Clifton-Fine Hospital.

_____ _____

Print Name Date

_____ _____

Patient/Parent (Guardian) Signature if Patient Under age of 18 years of age Witness