PLEASE COMPLETE EACH QUESTION BELOW
FORMS MAY BE FAXED TO 301 777-2173 OR EMAILED TO frontdesk1@handinstitutellc.com

PATIENT NAME_____

ADDRESS_____
Street City Zip

DATE OF BIRTH_____ **SOCIAL SECURITY #**_____

PRIMARY PHONE #_____ **SECONDARY PHONE #**_____

EMERGENCY CONTACT (NAME - RELATIONSHIP - PHONE #)

NAME_____ RELATION_____PHONE_____

MARITAL STATUS
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYMENT STATUS ☐ Full ☐ Part ☐ Unemployed ☐ Retired ☐ Student

NAME OF MEDICAL PERSON WHO PROVIDED
PRESCRIPTION/REFERRAL_____

DIAGNOSIS (As written on Prescription/referral)
_____

INSURANCE INFORMATION PLEASE TAKE THIS INFORMATION FROM YOUR INSURANCE CARD
NAME OF PRIMARY INSURANCE POLICY HOLDER _____

POLICY HOLDERS DATE OF BIRTH_____

PRIMARY INSURANCE_____

ID# _____ **GROUP #**_____

SECONDARY INSURANCE _____

ID# _____ **GROUP #** _____

I agree to pay The Hand Institute, LLC for all services not covered by my insurance company. In addition, I understand that I am responsible for all Co-Pays and deductibles per my insurance contract. I request that payment of authorized benefits be made on my behalf.
If I am not insured at the time of service, I understand that I am fully responsible for all services received.
Permission is hereby granted to The Hand Institute, LLC to release information to my insurance company, employer, attorney, worker's compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician.

☐ **I viewed/accepted a copy of the Privacy Practices of The Hand Institute, LLC.**

☐ **I declined a copy of the Privacy Practices of The Hand Institute, LLC.**

_____ _____ _____
PATIENT NAME **PATIENT / GUARDIAN SIGNATURE** **DATE**

Injury Detail Form

PLEASE COMPLETE:

Explain the principal cause you are coming for therapy including the location of the issue (Right/Left)

_____

_____

When did your problem start? _____

Is treatment due to surgery? ☐ Yes ☐ No Date of surgery: _____

Is treatment due to an accident? ☐ Yes ☐ No Date of accident: _____

If an accident, is it a Worker's Compensation accident? ☐ Yes ☐ No

If an accident, is it an auto accident? ☐ Yes ☐ No

Describe how accident happened

_____

_____

Location of accident_____

Have you received Occupational or Physical Therapy anywhere else for this condition ☐ Yes ☐ No

Name of treatment provider/facility _____

Number of Occupational or Physical Therapy visits you have received **this year**_____

Hand Dominance ☐ Right ☐ Left

When is your next visit with the referring physician?_____

If Worker's Compensation or Auto please complete the following section:

Name of Employer if Worker's Compensation _____

Phone Number_____ Adjustor's Name _____

Fax Number _____ Claim Number _____

Address for Claim Submission _____

_____

To the best of my knowledge this description is true, correct and complete.

_____ _____

Patient Signature **Date**

Intake Information

NAME _____

REFERRING PHYSICIAN/FAMILY PHYSICIAN_____

DATE OF INJURY_____**EMPLOYER**_____

YES **NO** Please check**YES** or **NO** on the appropriate line to answer the following health questions.

☐ ☐ Do you have High Blood Pressure?

☐ ☐ Do you have Diabetes? (Please check one) ☐ Type 1 ☐ Type 2 (Adult onset)

☐ ☐ Do you have any history of Cancer? Type/Area of body _____

☐ ☐ Do you have Osteoporosis?

☐ ☐ Do you have Osteoarthritis?

☐ ☐ Do you Use any form of Tobacco products? _____

☐ ☐ Do you have any history of Seizures?

☐ ☐ Do you have any history of Psychiatric illness?

☐ ☐ Are you or could you be Pregnant?

☐ ☐ Have you received any other treatment for the condition you are here for today?

☐ ☐ Do you experience any problems with dizziness?

☐ ☐ Have you fallen in the past year? How many times have you fallen in the past year_____

☐ ☐ Did you sustain any injury when you fell and if so, please explain?_____

☐ ☐ Do you have any communicable diseases, please explain. _____

Do you have any heart problems or history of?

☐ Heart attack ☐ Pacemaker ☐ Cardiac Stents ☐ Bypass Surgery ☐ Heart Murmur ☐ Congestive Heart Failure

_____

DO YOU HAVE ANY OTHER MEDICAL HISTORY NOT MENTIONED ABOVE?

_____

_____

ALLERGIES:_____

_____

MEDICATION LIST: Including dosage amounts and times taken per day. You may send a printed list from your pharmacy if desired.

1._____ 2._____ 3._____

4. _____ 5. _____ 6. _____

7._____ 8._____ 9._____

_____ _____

PATIENT SIGNATURE/DATE **PROFESSIONAL SIGNATURE/DATE**

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum/maximum using the last 3 months as your reference. If you have completed this form before, indicate your average pain level since the last time you completed this form.

0 = no pain at all 1-3 = Mild 4-5 = Moderate 6-7 = Severe 7 – 8 Very Severe 9-10 = Worst pain ever

1. **What is your pain RIGHT NOW?**

No Pain ---------- Worst possible pain

☐0☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

2. **What is your TYPICAL or AVERAGE pain?**

No Pain ---------- Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

3. **What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

No Pain ---------- Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

4. **What percentage of your awake hours is your pain at its best? _____%**

5. **What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

No Pain ---------- Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

6. **What percentage of your awake hours is your pain at its worst? _____%**

Patient Name_____

_____

DO NOT WRITE BELOW THIS LINE. FOR USE THERAPIST ONLY

Name_____Age_____Date_____Score_____

Score: #1_____+#2_____+#4_____=_____/3 x 10 =_____(low intensity =<50; High intensity= >50)

QuickDASH

Patient Name:_____ Date:_____

OUTCOME MEASURE

INSTRUCTIONS: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer every question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

BASED ON YOUR TOTAL BODY FUNCTION (NOT LIMITED TO YOUR CONDITION FOR THE TREATMENT YOU ARE SEEKING CARE FOR TODAY) PLEASE RATE YOUR ABILITY TO DO THE FOLLOWING ACTIVITIES IN THE LAST WEEK:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food	1	2	3	4	5
6. 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

LIMITED TO YOUR CONDITION FOR THE TREATMENT YOU ARE SEEKING CARE FOR TODAY, PLEASE INDICATE YOUR LEVELS FOR THE FOLLOWING IN THE LAST WEEK:

7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends etc.?

NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
1	2	3	4	5

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8. 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?

NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
1	2	3	4	5

	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

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11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?

NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY I CAN'T SLEEP
1	2	3	4	5

QuickDASH DISABILITY/SYMPTOM SCORE = (sum of n responses) - 1 x 25, where n is equal to the number of completed responses.

QuickDASH score may not be calculated if there is greater than 1 missing item.

QuickDASH

WORK MODULE (OPTIONAL)

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

Please indicate what your job/work is _____

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

Please check the level that 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.

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 check the level that 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 practicing 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.