Hand and Upper Body REHABILITATION CENTER

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Client Intake Form

Name: _____ MALE OR FEMALE Date: _____

Address: _____ City: _____ State: _____Zip: _____

SSN: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Hand & Upper Body may update you via e-mail time to time on health & Wellness tips or our programs & services. Indicate if you do NOT wish to be included in these updates: _____

Date of Birth: _____ Hand Dominance: ¡ Right ¡ Left ¡ Ambidextrous

Emergency Contact _____ Emergency Contact Phone Number _____

Referring Physician: _____ Family Physician: _____

If patient is a minor, who is financially responsible for treatment? _____

How did you hear about our services? ¡ Doctor ¡ PA/Nurse ¡ Chiropractor ¡ Friend/family ¡ Telephone Book ¡ Internet ¡ Other: _____

Are you currently in a Skilled Nursing Facility or Nursing Home? ¡ Yes ¡ No If yes, where? _____

Are you currently receiving therapy anywhere else? ¡ Yes ¡ No For what problem? _____

Are you currently receiving Home Health Services? ¡ Yes ¡ No

INSURANCE: Insurance Carrier: _____

Policy Holder Name and Address: _____

Relationship to Patient: _____

ID#:_____Group #: _____

Do you have a Workers Compensation Claim for this injury? ¡ Yes ¡ No If yes, Claim #: _____

Age: _____ Height: _____ Weight: _____ Lbs. BMI (Calculated by therapist) _____

Comorbidities: (circle all that apply)

Cancer (what type) _____	Pacemaker/Cardiac	Stroke / CVA	Cardiovascular Disease
Neuropathy	Arthritis (OA RA)	Infection	Diabetes (I II)
Head Injury	COPD / Breathing Problems	Hypertension	High Blood Pressure
Lymphedema	Epilepsy/Seizures	Dementia	Neck / Back pain
Other: _____	Osteoporosis/Osteopenia	Depression/Anxiety	Parkinson's

Previous Arm, Shoulder, Neck, Hand Injuries or Surgeries: _____

_____

_____

Do you have any metal implants or artificial joints? ¡ Yes ¡ No Where: _____

Smoker: ¡ Non-smoker ¡ Current ¡ Past **Are you pregnant?** ¡ Yes ¡ No

Are your Stressed? ¡ Yes ¡ No **Are you Depressed?** ¡ Yes ¡ No

Allergies/Sensitivities: _____

Medications: (MAY ATTACH LIST) _____

_____

Have you had any illness in the past 3 weeks? (cold, flu, bladder or respiratory infection) ¡ Yes ¡ No

Have you had a change in your health in the past 3 months? ¡ Yes ¡ No

_____ _____ _____

Patient Signature **Date** **Therapist initial**

***** PLEASE SEE OTHER SIDE *****

The Quick DASH Outcome Measure

NAME: _____ **DATE:** _____

INSTRUCTIONS: This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer EVERY question, based on USING YOUR INJURED HAND/ARM in the last week.

If you were in a **cast or had surgery** and can't do the activities, **please circle 5: Unable to Perform.**

If you did not have the opportunity to perform an activity in the past week, please make your **best estimate** to answer each question.

If you have a question, please wait & discuss with your therapist.

	No difficulty	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Unable to perform**
1. Open a tight or new jar.	**1**	**2**	**3**	**4**	**5**
2. Do heavy household chores (Wash walls, floors).	**1**	**2**	**3**	**4**	**5**
3. Carry shopping bag.	**1**	**2**	**3**	**4**	**5**
4. Wash your back.	**1**	**2**	**3**	**4**	**5**
5. Recreational activities in which you take some force or impact thru your arm, shoulder or hand. (golf, hammer)	**1**	**2**	**3**	**4**	**5**
6. Use knife to cut food.	**1**	**2**	**3**	**4**	**5**

	Not at all	**Slightly**	**Moderately**	**Quite a bit**	**Extremely**
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	**1**	**2**	**3**	**4**	**5**

	Not limited at all	**Slightly limited**	**Moderately limited**	**Very limited**	**Unable**
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?	**1**	**2**	**3**	**4**	**5**

Please rate the **severity** of the following symptoms **in the past week**:	**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**
	No difficulty	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**So much that I can't sleep**
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	**1**	**2**	**3**	**4**	**5**

Quick DASH Disability/Symptom Score: ((sum of n responses)/n) -1 x 25, where n = number of completed responses. Total: _____

Quick DASH score may not be calculated if there is greater than 1 missing item. MCID 8 points. Dash Score: _____

*** **PLEASE SEE OTHER SIDE** ***