

Lakeshore Sports

PHYSICAL THERAPY

Personal Information:

First Name: _____ MI: _____ Last Name: _____

Prefers to be called: _____ Date of Birth: _____ Sex: Male Female

E-mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Where do you prefer to receive calls? Home Work Cell

How do you prefer to receive appointment reminders? Text Message (Standard rates will apply) Phone Message

May we notify you of upcoming classes and lectures? Yes No

Select the locations where we may leave messages that may contain health information about you:

Home Work Cell None (please do not leave messages containing health information)

Is there anyone involved in your care with whom we may discuss your health information?

Spouse: _____ Other: _____

Referring Physician: _____ Internist: _____

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Marital Status: Single Married Divorced Widowed Separated Partnered

Employment Status: Active Duty Full-Time Part-Time Retired Student None

Is this injury related to an auto accident? Yes No If so, in which state did the accident occur? _____

Is this injury related to another type of accident? Yes No Is an attorney involved? Yes No

Is this a work-related injury? Yes No

Primary Insurance:

Secondary Insurance:

Name of Insured Party: _____

Date of Birth of Insured: _____

Relationship to Insured: _____

Insurance Company: _____

Insured's Employer Information:

Employer's Name: _____ Occupation: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Consent to Treat, Authorization and Release:

I, for myself (or the patient/client named below), hereby consent to such medical treatment as necessary and appropriate for my condition or illness in the judgment of my physical therapist, to be performed by my physical therapist. I certify that the information given by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate. I authorize the release of any information to third party payers and entities involved in billing and collection in order to process my claims. I authorize and request my insurance company to pay directly to Lakeshore Sports Physical Therapy insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I acknowledge that I have received the *New Client Information* and *Privacy Policies* brochures. I understand that members of Lakeshore Sports Physical Therapy's professional staff may be employees of the organization or independent associates of the practice and that I may ask if I would like to clarify my therapist's relationship with Lakeshore Sports Physical Therapy, PC.

Signature: _____

Date: _____

OFFICE USE ONLY

Referral Source: Physician Patient Returning Patient Insurance Yellow Pages Other: _____

Primary Therapist: AWP SP IH KBB EF

Date of Injury: _____ Have you had this injury before? Yes No If so, when? _____

Name: _____

DOB: _____

HEALTH HISTORY

1. **Are you:** Right-handed?
 Left-handed?

2. Employment/Task Demands

How many hours do you spend in computer/desk work per day? _____
 How much and how often do you lift objects heavier than 10 pounds?

of times/day: _____
 Average weight of items lifted: _____

3. **Where do you live?**
 House Apartment

4. **Accessible by:** Stairs Elevator

5. **With whom do you live?**
 Alone Spouse Partner
 Child Other relative
 Pets Other

6. **Do you use an assistive device for mobility?**
 Yes No

If yes, please name: _____

7. **Do you have any uncorrected vision or hearing problems?**

- Yes No

8. Medications

Do you currently take any prescription medications?

- Yes No

If yes, please list (include dosages): _____

Do you currently take any nonprescription medications?

- Antacids Ibuprofen/
 Antihistamines Naproxen
 Aspirin Laxatives
 Decongestants Tylenol
 Herbal supplement Vitamins

Other: _____

If yes, please list dosages: _____

9. Health Habits

Please rate your health:

- Excellent Good
 Fair Poor

Do you exercise beyond your daily activities or participate in any hobbies or sports?

- Yes

Please describe the exercise, sport or hobby:

How many days per week do you exercise or perform physical activity? _____

For how many minutes, on an average day? _____

- No

Do you currently use or have you previously used tobacco?

- Yes Cigarettes, # of packs/day: _____

Cigars, # per day/week: _____

Chewing tobacco: _____

Year quit, if applicable: _____

- No

How many days per week do you drink beer, wine or other alcoholic beverages? _____

How many caffeinated beverages do you drink on an average day?

Do you have a history of chemical dependency?

- Yes No

10. Within the past year, have you had any of the following medical tests?

<input type="checkbox"/> Angiogram	<input type="checkbox"/> MRI
<input type="checkbox"/> Arthroscopy	<input type="checkbox"/> Myelogram
<input type="checkbox"/> Biopsy	<input type="checkbox"/> NCV (nerve conduction velocity)
<input type="checkbox"/> Bone scan	<input type="checkbox"/> Pulmonary function test
<input type="checkbox"/> Doppler ultrasound	<input type="checkbox"/> Stress test (such as treadmill, bicycle)
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> X-rays
<input type="checkbox"/> EKG (electrocardiogram)	
<input type="checkbox"/> EMG (electromyogram)	

11. Have you ever had surgery?

- Yes No

If yes, please describe and include year:

DISABILITIES OF THE ARM, SHOULDER, AND HAND

Patient Name: _____

Date: _____

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

ACTIVITIES	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 or 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. card playing, knitting)	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)	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g. playing Frisbee, badminton)	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
TOTAL					

DISABILITIES OF THE ARM, SHOULDER, AND HAND

	Not at all	Slightly	Moderately	Quite a bit	Extremely
22. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups? <i>(circle number)</i>	1	2	3	4	5

	Not Limited	Slightly Limited	Moderately Limited	Very Limited	Unable
23. During the past week, were you limited in your or other regular activities as a result of your arm, shoulder, or hand problem? <i>(circle number)</i>	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 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? <i>(circle number)</i>	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. <i>(circle number)</i>	1	2	3	4	5
TOTAL					

DASH Disability/Symptom Score = $\frac{[(\text{sum of } n \text{ responses}) - 1] \times 25}{n}$, 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.