

THE

DASH

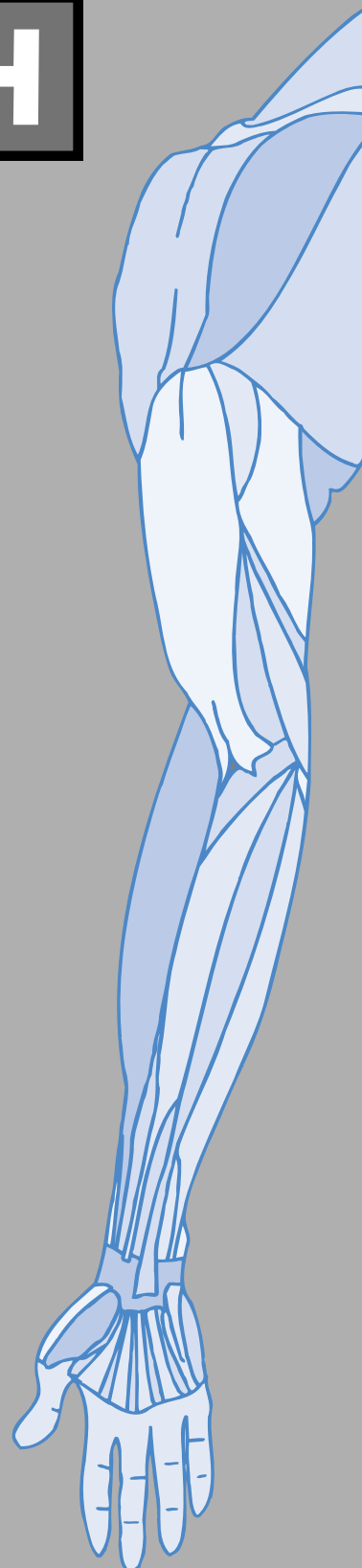
INSTRUCTIONS

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* on 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.



DISABILITIES OF THE ARM, SHOULDER AND HAND

SportsCare Physical Therapy, PC (516) 420-1927

Patient Name: _____

Date: _____

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

Patient Name: _____

Date: _____

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

DASH score: _____

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 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 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

Patient Name: _____

Date: _____

SportsCare Physical & Aquatic Therapy

Medical/Physical History Form

NECK/UPPER EXTREMITIES

Patient Name: _____ Diagnosis: _____ Date: _____

Age _____ Height: _____ inches Weight: _____ lbs.

Name of your doctor: _____ Type of doctor: Off

Date of Injury: _____ Date of Surgery: _____

History of present illness/injury/pain: _____

Primary Concern: (Why am I here for physical therapy): Off

Check all that apply:

1. Base level of function: house cleaning laundry reaching twisting hand/arm grasping lifting
(was able to do) taking off/putting on shirt/bra pushing object pulling object turning head

2. Functional limitation(s): house cleaning laundry reaching twisting hand/arm grasping lifting
(can't do) taking off/putting on shirt/bra pushing object pulling object turning head

Pain scale: (0 is best, 10 is worst)>>> worst: Off current: Off at best: Off

Pain description: Off Pain behavior in 24 hour cycle: Off Pain frequency: Off

Aggravating factors: Off

Better with: Off

General Health: Off

Previous history of similar symptoms: Off How many episodes? Off The year of 1st episode? _____

History of falls: Off how many? Off

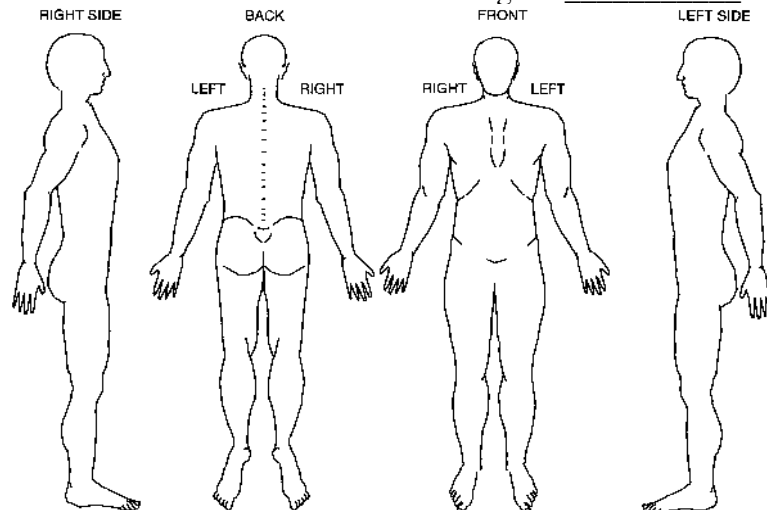
Medical History: No know significant medical history

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Strain |
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Obesity | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Bone fracture |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Parkinson | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Traumatic brain injury | <input type="checkbox"/> Cancer | <input type="checkbox"/> Spinal surgeries |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Allergies: _____ |

Diagnostic Testing/Imaging: MRI CT scan X ray Findings: _____

What are your goals in physical therapy? _____

Identify the area(s) of your concern by moving your cursor over the site(s) of your symptoms and checking them off (X) >>>



OFFICE USE ONLY

Off Total Score: _____ pts; _____ %

Off Total Score: _____ pts; _____ %

SportsCare Physical Therapy, PC

Date of call _____ Appt. date/time _____

Name _____ Date of Birth _____ SS# _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Spouse _____ Email address _____

If Child, Parents Names _____

Employer Name/Address _____ Occupation _____

Emergency contact _____ Phone # _____ Relationship to patient _____

Referring MD ^{Off} Name _____ Town _____

Primary Care Name _____ Town _____

Which body part are you going to be treated for? _____

Was this the result of a car accident or work related injury? Yes No Date of accident _____

Did you have previous physical therapy this year? Yes No If yes, how many visits _____ Off

How did you hear about us? Off Family/Friend name: _____

What is your primary insurance? ^{Off} Other: _____

Name _____ Address _____ Phone _____

ID# _____ Grp# _____ Subscriber _____ DOB: _____

Subscriber SS# _____ Relationship to patient _____

What is your secondary insurance? ^{Off} Other: _____

Name _____ Address _____ Phone _____

ID# _____ Grp# _____ Subscriber _____ DOB: _____

Subscriber SS# _____ Relationship to patient _____

IF WORKERS COMP/NO FAULT INSURANCE, PLEASE FILL IN:

Name _____

Address _____ Phone _____ Fax _____

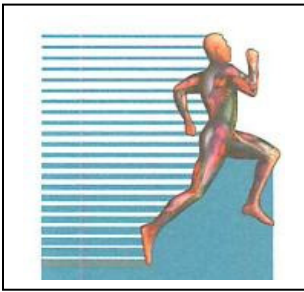
WCB# _____ Carrier Case # _____ File/Claim# _____

Policy # _____ Policy Holder _____ Claim Rep _____

Employer at time of accident _____

I authorize SportsCare Physical Therapy, PC to release any information to my insurance company that is necessary to expedite the payment of my claims. I understand that I am responsible for all charges not covered by my insurance including co-payments, co-insurance and deductibles. I understand that if my account is placed in collection, I am responsible for any and all fees associated with being placed into collection and legal proceedings. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions when appropriate and that if said referrals are not obtained, I am responsible for the charges not covered under the referral. I authorize benefits to be paid to SportsCare Physical Therapy, PC. I authorize SportsCare Physical Therapy, PC to contact the insurance commissioner on my behalf. In the event that my workers compensation or no fault claim is denied, I will make arrangements with SportsCare Physical Therapy, PC to be paid by my private insurance and/or myself.

Patient Signature (or Signature of Parent or Guardian) _____ Date _____



SportsCare Physical Therapy, PC
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 www.sportscareptpc.com

RELEASE OF INFORMATION

I give consent to SportsCare Physical Therapy, PC to disclose or request all or any part of the patient’s medical record to any person or entity which is or may be liable under a contract to the facility, family member or employer of the patient for all or part of the facilities charge, including, but not limited to physical therapy services, insurance companies, workers compensation/no fault carriers, welfare funds or the patient’s employer or any New York State or Federal agency per current rules and regulations. SportsCare Physical Therapy, PC has the authority to reject any unreasonable request by an office or institution if such request might violate the patient’s right to privacy. I understand that confidentiality of my medical records are protected under state and federal law and that this release gives the consent to SportsCare Physical Therapy, PC only and not to any party to whom such information is released.

Patient/Responsible Party initials: _____

ASSIGNMENT OF BENEFITS

I hereby assign and set forth SportsCare Physical Therapy, PC sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of care and treatment rendered to me or my dependent. I request that payment of authorized insurance benefits be made on my behalf directly to SportsCare Physical Therapy, PC.

Patient/Responsible Party initials: _____

CONSENT TO TREAT

I hereby request and consent to SportsCare Physical Therapy, PC to perform physical therapy treatment as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy treatment may have some risk. I understand that I have the right to ask about these risks and have any questions answered about my condition and treatment at any time during the course of my care. I authorize the physical therapist to provide any additional care or treatment, which is deemed necessary, should during the course of treatment such action be warranted. I understand that following an initial evaluation and appropriate re-evaluations, a description of my condition/diagnosis, presenting signs and symptoms, contraindications and precautions to treatment and expected benefits of treatment will be explained to me. I have read and understand this consent and authorize SportsCare Physical Therapy, PC (including physical therapist assistants and physical therapy students in training) to administer treatment under the direction and supervision of the physical therapist.

Patient/Responsible Party initials: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SportsCare Physical Therapy, PC is committed to preserving the privacy of your personal health information. We have available a detailed notice of privacy practices which explain your rights and our obligations under the law. I acknowledge on this date that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

Patient/Responsible Party initials: _____

We value your time and as such, appointment times are at a premium. To get the best results from your treatment, it is imperative that you attend PT consistently. **If you cancel, please do so 24 hours in advance.** This will allow another patient to obtain that spot and receive their treatment. You may be subject to calling for available appointments (we will not pre book appointments) if you “No Show” (miss without calling) 3 visits. No Showing for appointments prevents someone else from receiving treatment and leaves us with an empty time in our work day. In addition, your insurance company may inquire about your attendance which may affect their determination in approving and paying for continued treatment. **Cancellations made within 24 hours of your appointment and “No Shows” will be charged a \$25.00 fee.** This is neither billable nor payable by your insurance company and will be your responsibility.

Copayments are due upon arrival and prior to treatment. We accept cash, checks and credit cards (Visa, MC, Discover).

 Patient/Responsible party signature

Off / Off / Off

 Date

 SCPT team member signature

Off / Off / Off

 Date