*Florida GulfCoast*
*Physical Therapy LLC*

# PATIENT INFORMATION SHEET

**Patient Name**________________________________________ **Phone #**________________________________
**Address (Florida):**____________________________________________________________________________
**City**__________________________ **State**_________________________ **Zip Code**_____________________
**Address (Not Florida):**_________________________________________________________________________
**City**__________________________ **State**_________ **Zip Code**__________ **Phone #**_________________
**Social Security #**_____________________________________ **Birth date**_______________________________
**Sex (circle one)** Male Female
**Marital Status (circle one)** Single Married Divorced Separated Widowed
**Insurance Company (Primary)**___________________________ **ID#**________________ **Phone #**_______________
**Insurance Company (Secondary)**_________________________ **ID#**________________ **Phone #**_______________

**Please fill out the following information if your insurance is not in your name:**

**Insured's Name**__________________________________ **Relation**______________ **DOB**_________________
**Address**_________________________________________________________________________________
**City**__________________________ **State**_________________________ **Zip Code**______________________

**Are you able to work?**(circle) yes no **Occupation**_________________________ (circle) Full time Part time
**Employer**___________________________________________ **Phone #**________________________________
**Address**_________________________________________________________________________________
**City**__________________________ **State**_________________________ **Zip Code**______________________

Date of injury, surgery or onset of symptoms (mm/dd/yy) please be specific___________________________________
Possible cause for injury (fall, car accident, work related):___________________________________________
If due to car accident or work, did you report the accident? (circle one) Yes No

**Please fill out the following information if you were in a motor vehicle accident:**

**Insurance Company**___________________________________ **Phone #**________________________________
**Address**_________________________________________________________________________________
**City**__________________________ **State**_________________________ **Zip Code**______________________
**Case Manager**________________________________________ **Claim #**________________________________
**Attorney**___________________________________________ **Phone #**________________________________
**Address**_________________________________________________________________________________
**City**______________________ **State**_______________________ **Zip Code**______________________

**Please fill out the following information if you sustained your injury at work:**

**Insurance Company**___________________________________ **Phone #**________________________________
**Address**_________________________________________________________________________________
**City**__________________________ **State**_________________________ **Zip Code**______________________
**Case Manager**________________________________________ **Claim #**________________________________

**Are you currently receiving any other treatments:**__________________________________________________
**Are you currently receiving home health services:** Yes No **If yes answer below**
**Home health company name**_____________________________________________________________________
**Phone #**______________________________________ **Contact** ___________________________________________
**When was your last visit?**________________________ **Are they scheduled to return?** Yes No

**Thank you for your cooperation. If you are unable to keep your scheduled appointments, please notify us within 24 hours before your scheduled appointment time. A $25 fee will be assessed for missed appointments without a 24 hours notice.**

**I have read and understand the policy regarding fees and agree to pay any remaining balance. I authorize payment directly to Florida GulfCoast Physical Therapy. I authorize consent to copy and release PT records of treatment, charges, and reports to physicians and other parties, as indicated.**

**What are your goals for therapy?** ___________________________________________________________________

**Patient Signature:**_____________________________________ **Date**______________________________

Florida GulfCoast
Physical Therapy LLC

Phone: 239-948-2222
Fax: 239-948-2225
Web: flgulfcoastpt.com

**Name**______________________________________________________________________________
**Diagnosis / complaint**______________________________________________________________
**Date of injury / onset of symptoms**___________________________________________________
**Symptoms**___________________________________________________________________________
**Tests:**(circle all that apply) **x-ray** **MRI** **CT scan** **arthrogram** **sonogram** **EMG** **NCV** **Bone density**
**Results:**_____________________________________________________________________
**Pain description:** (circle all that apply) **Sharp** **Dull** **Achy** **Shooting** **Stabbing** **Stiff** **Throbbing**
**Other:**______________________________________________________________________
**Do you experience:** (circle all that apply) **Numbness** **Tingling** **Burning** **Weakness** **Cramping**
**Other:**______________________________________________________________________

**Please mark the lines below as indicated**

**Pain at best (0/10 = no pain, 10/10 pain = emergency)**

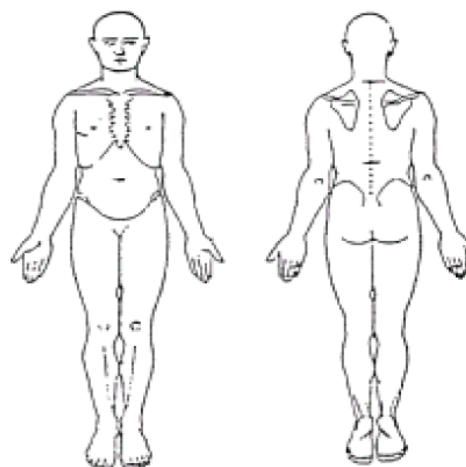
**0____________________5____________________10**

**Pain at worst (0/10 = no pain, 10/10 pain = emergency)**

0____________________**5**____________________**10**

**Current pain (0/10 = no pain, 10/10 pain = emergency)**

0____________________**5**____________________**10**




Put an 'X' on the diagram above where you feel pain.

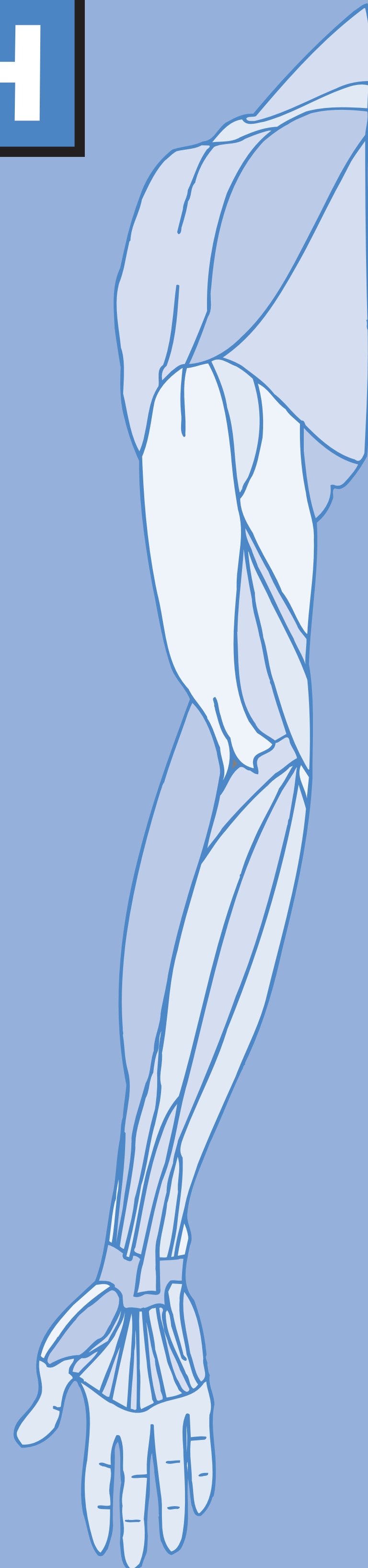
**Is your pain:** (circle) Constant Intermittent At regular intervals
**Does your pain:** (circle) prevent sleep wake you from sleep feel better after sleep feel worse after sleep not influenced by sleep
**What increases your symptoms?**_____________________________________________________
**What decreases your symptoms?**____________________________________________________
**Do you have any of the following:** (circle)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Yes | No | **Heart condition/Heart Attack** | Yes | No | **Stroke** | Yes | No | **Diabetes** |
| Yes | No | **Asthma** | Yes | No | **High Blood Pressure** | Yes | No | **Low Blood Pressure** |
| Yes | No | **Anemia** | Yes | No | **Seizures / Epilepsy** | Yes | No | **Severe / Chronic Headaches** |
| Yes | No | **Arthritis** | Yes | No | **Pacemaker** | Yes | No | **Osteoporosis** |
| Yes | No | **Kidney Disease** | Yes | No | **Hepatitis / Jaundice** | Yes | No | **Hearing loss** |
| Yes | No | **Circulatory Problems** | Yes | No | **Recent Weight Gain / Loss** | Yes | No | **Dizziness / Loss of Balance** |
| Yes | No | **Incontinence** | Yes | No | **Pregnant** | Yes | No | **Cancer** |

**Other:**_____________________________________________________________________________
**During the past 5 years have you been admitted to the hospital or had surgery?**(circle) **Yes** **No** **If Yes explain:**
Date: ___________ Reason: ____________________________________________________________
Date: ___________ Reason: ____________________________________________________________
Date: ___________ Reason: ____________________________________________________________
**Have you had any previous orthopedic problems, injuries or surgeries?**
Date:_______ Diagnosis_____________ Date:_______ Diagnosis_____________ Date:_______ Diagnosis_____________
Date:_______ Diagnosis_____________ Date:_______ Diagnosis_____________ Date:_______ Diagnosis_____________

**Patient Signature:**_____________________________________ **Date**_____________________________

# 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.

Only fill out the optional work module or sports / performing art module if they are pertinent.

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

# 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:___________________________

p 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:_

o 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 |

**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.**

INSTITUTE FOR WORK & HEALTH
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# Current Medication List

| Medication | Dosage | Frequency | How is drug administered? | | | |
|---|---|---|---|---|---|---|
| | | | Oral | Transdermal | Suppository | Injection |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
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| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |