



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 _____



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

Right Left Left Right

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

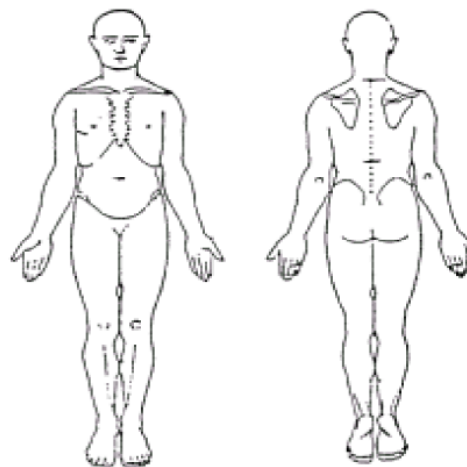
0 _____ 5 _____ 10 _____

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 _____

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity

- (0) I have no pain at the moment.
- (1) The pain is very mild at the moment.
- (2) The pain is moderate at the moment.
- (3) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)

- (0) I can look after myself normally without extra pain.
- (1) I can look after myself normally but it causes extra pain.
- (2) It is painful to look after myself and I am slow and careful.
- (3) I need some help but manage most of my personal care.
- (4) I need help every day in most aspects of self care.
- (5) I cannot get dressed, wash with difficulty and stay in bed

3. Lifting

- (0) I can lift heavy weights without extra pain.
- (1) I can lift heavy weights but it gives me extra pain.
- (2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
- (3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Headache

- (0) I have no headaches at all.
- (1) I have slight headaches which come infrequently.
- (2) I have moderate headaches which come infrequently.
- (3) I have moderate headaches which come frequently.
- (4) I have severe headaches which come infrequently.
- (5) I have headaches almost all the time.

5. Recreation

- (0) I am able engage in all my recreational activities without pain.
- (1) I am able to engage in my recreational activities with some pain.
- (2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
- (3) I am able to engage in a few of my usual recreational activities with some neck pain.
- (4) I can hardly do any recreational activities because of neck pain.
- (5) I can't do any recreational activities at all.

6. Reading

- (0) I can read as much as I want with no pain in my neck.
- (1) I can read as much as I want with slight neck pain.
- (2) I can read as much as I want with moderate neck pain.
- (3) I can't read as much as I want because of moderate neck pain.
- (4) I can hardly read at all because of severe neck pain.
- (5) I cannot read at all because of neck pain.

7. Work

- (0) I can do as much as I want to.
- (1) I can only do my usual work but no more.
- (2) I can do most of my usual work but no more.
- (3) I cannot do my usual work.
- (4) I can hardly do any usual work at all.
- (5) I can't do any work at all.

8. Sleeping

- (0) Pain does not prevent me from sleeping well.
- (1) My sleep is slightly disturbed (<1 hr sleep loss).
- (2) My sleep is mildly disturbed (1-2 hr sleep loss).
- (3) My sleep is moderately disturbed (2-3 hr sleep loss).
- (4) My sleep is greatly disturbed (3-4 hr sleep loss).
- (5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration

- (0) I can concentrate fully when I want with no difficulty.
- (1) I can concentrate fully when I want with slight difficulty.
- (2) I have a fair degree of difficulty concentrating when I want.
- (3) I have a lot of difficulty concentrating when I want.
- (4) I have great difficulty concentrating when I want.
- (5) I cannot concentrate at all.

10. Driving

- (0) I can drive my car without neck pain.
- (1) I can drive my car as long as I want with slight neck pain.
- (2) I can drive my car as long as I want with moderate neck pain.
- (3) I can't drive my car as long as I want because of moderate pain.
- (4) I can hardly drive my car at all because of severe neck pain.
- (5) I can't drive my car at all.

Neck Disability Index © Vernon H. and Mior S., 1991.

Therapist Use Only	
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas
	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
	ICD9 Code: _____

THE

DASH

INSTRUCTIONS

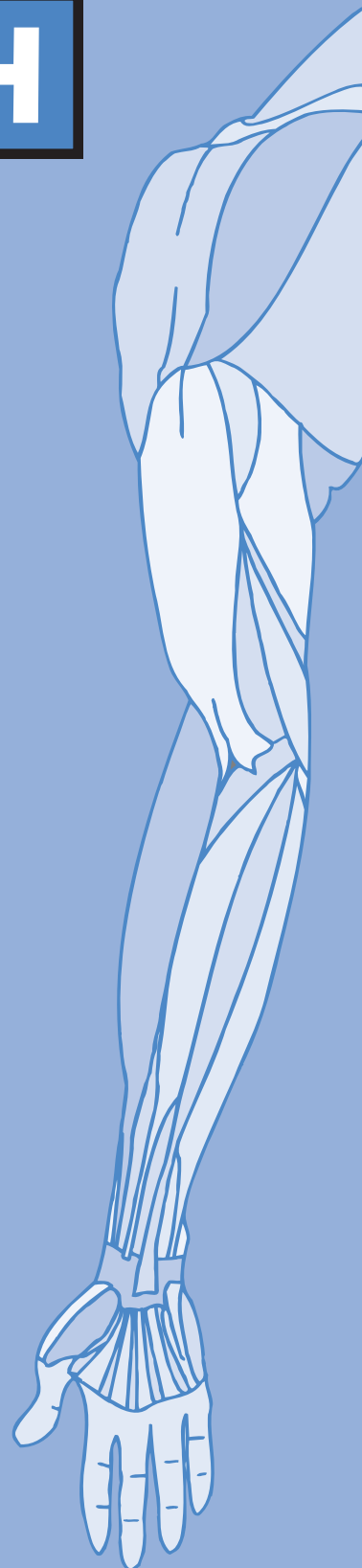
This questionnaire asks about your symptoms as well as your ability to perform certain activities.

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, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? <i>(circle number)</i>	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? <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 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? <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

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.

