



Patient Medical History

Name: Referring Physician:
Family Physician: First Doctor Visit for Injury:
Last date worked due to injury: Date returned to work after injury:
Is there an attorney involved in this case? Date of next Doctor visit:
Have you had surgery for this injury? Number of Surgeries: Date(s):
Type of Surgery:
Where did your surgery take place:

Current Level of Pain (0 being no pain, 10 being pain requiring Emergency Room Care)
(Circle only one) 1 2 3 4 5 6 7 8 9 10

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATION:
If yes, please list:

- PLEASE CHECK ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES YOU HAVE RECEIVED FOR THIS CONDITION
Orthopedist Physical Therapy X-Rays EMG
Occupational Therapy CT Scan NCV Neurologist
Massage Therapy MRI Injection General Practitioner
Myelogram Cast or Brace Emergency Room Care
Chiropractor Other

PLEASE CIRCLE ANY OF THE FOLLOWING ITEMS THAT PERTAIN TO YOUR HEALTH HISTORY

- Asthma Sleeping Problems Allergies Shortness of Breath
Emotional Psychological Anemia Coronary Heart Disease
Headaches Infectious Disease Chest Pain Numbness or Tingling
Neurological Problems Do you have a Pacemaker? Dizziness or Fainting Diabetes
High Blood Pressure Blurred Vision Metal Implants Heart Attack
Ringing in the Ears Cancer Heart Surgery Weakness
Do you Smoke? Epilepsy or Seizures Arthritis or Swollen Joints Blood Clot or Emboli
Night Sweats/Pain Are you Pregnant? Hernia Osteoporosis
Thyroid Trouble Urinary Problems Recent Fever Pain Unrelieved by position or rest
Varicose Veins Stroke/TIA (Date) Alcohol/Drug Dependence Abnormal Weight Gain/Loss
Other:

PLEASE LIST ANY SURGERIES YOU HAVE HAD IN THE PAST:

PLEASE LIST THREE GOALS YOU WOULD LIKE TO ACHIEVE WHILE IN THERAPY:
1.
2.
3.

EMERGENCY CONTACT: PHONE:

PATIENT OR GUARDIAN SIGNATURE: Date:



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## **GENERAL CONSENT AND ACKNOWLEDGEMENT**

### **CONSENT FOR DIAGNOSIS, CARE AND TREATMENT**

I understand and acknowledge that this General Consent and Acknowledgement applies to care and treatment I receive at Greenwood Physical Therapy.

I consent to and authorize the physical therapists and other health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my well being. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at Greenwood Physical Therapy. I understand that health care providers in training, including students, may be involved in my care and treatment and I consent to their involvement in my care. I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow-up care; I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Greenwood Physical Therapy will be my responsibility.

\_\_\_\_\_ Initial

### **USE AND DISCLOSURE OF HEALTH INFORMATION**

I understand that Greenwood Physical Therapy will use and disclose my health information for the purposes of treatment, payment, and healthcare operations. I understand, acknowledge and consent to the release of my personal health information for the purposes outlined in this section, as described in the Notice of Privacy Practices which has been offered to me, and as may otherwise be permitted by law.

\_\_\_\_\_ Initial

### **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of Greenwood Physical Therapy's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended Notice of Privacy Practices at each appointment. In accordance with the policy there will be no electronic devices allowed in the gym area. I understand the information Greenwood Physical Therapy acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the notice or as authorized by me in writing.

\_\_\_\_\_ Initial

268 Greenwood Ave  
Suite 202  
Bethel, CT 06801  
Phone 203-917-4792 \* Fax 203-917-4798



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**CANCELLATION AND NO SHOW POLICY**

Your physician has recommended physical therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments. Your therapist will advise you at your evaluation how many times a week it will be necessary for you to attend. ALL appointments missed MUST be made up in the same week so you may fully recover. Greenwood Physical Therapy requires 24 hours notice for any cancellation. If you do not give 24 hour advance notice for any cancellation or you do not show for your scheduled appointment an administrative fee of \$25 will be billed to you.

\_\_\_\_\_ Initial

**ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT**

I guarantee payment of all charges incurred for services rendered by Greenwood Physical Therapy for the patient name on the top of the page. I guarantee the amount due for non-insurable charges including co-payment, deductibles, etc. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize Greenwood Physical Therapy to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. I, as the responsible party, agree to furnish Greenwood Physical Therapy with up-to-date insurance. Any changes in insurance coverage must be reported to the office immediately. If my insurance plan requires a referral for me to come to Greenwood Physical Therapy, I understand that I am responsible for securing that referral. I further acknowledge that failure to do so may mean that I will not be seen upon arrival at the office. Acceptable methods of payment are cash, check or any card except AMEX.

\_\_\_\_\_ Initial

\_\_\_\_\_  
*Signature of Patient or Responsible Party if Minor*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please print name of patient*

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# QuickDASH

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. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. 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

	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, neighbours 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 last week. (circle number)

	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 DIFFICULTY 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? (circle number)	1	2	3	4	5

QuickDASH DISABILITY/SYMPTOM SCORE =  $\left( \left[ \frac{\text{sum of } n \text{ responses}}{n} \right] - 1 \right) \times 25$ , where n is equal to the number of completed responses.

A QuickDASH score may not be calculated if there is greater than 1 missing item.