Dublin Family Physical Therapy
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Consent to Receive Electronic Communications

Patient Name: _____ Date: _____

Please check below:

- ☐ I Agree
- ☐ I Do Not Agree

That Dublin Family Physical Therapy, LLC may communicate at the email and/or mobile number listed below. I am aware that there is some level of risk that third parties may be able to read unencrypted emails. Dublin Family Physical Therapy, LLC will always provide HIPAA compliant encrypted emails for any communication that contains sensitive health or personal information. I further agree that I am responsible for updating Dublin Family Physical Therapy, LLC of any changes to my email address and/or mobile phone number.

My preferred method of electronic communication:

- ☐ Text Messaging
- ☐ Email
- ☐ Both

Email: _____

Mobile Phone Number: _____

I can withdraw my consent to electronic communication at any time by notifying Dublin Family Physical Therapy, LLC.

Patient Signature: _____ Date: _____

PATIENT INFORMATION

NAME: FIRST _____ LAST _____ DATE OF BIRTH _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____ CELL: ( ) _____ HEIGHT: _____ WEIGHT: _____

EMERGENCY CONTACT NAME _____ PHONE _____

RELATIONSHIP _____

HAVE YOU HAD ANY PHYSICAL THERAPY TREATMENT THIS YEAR? Y N HOW MANY? _____

HAVE YOU HAD ANY CHIROPRACTIC TREATMENT THIS YEAR? Y N HOW MANY? _____

PHYSICIAN WHO REFERRED YOU TO PHYSICAL THERAPY _____

NEXT APPOINTMENT WITH PHYSICIAN WHO REFERRED YOU _____

PRIMARY CARE PHYSICIAN _____

EMPLOYMENT INFORMATION

EMPLOYER NAME _____ OCCUPATION _____

EMPLOYER ADDRESS _____ WORK PHONE _____

CITY, STATE, ZIP _____ DID INJURY OCCUR AT WORK? Y N

DID INJURY OCCUR IN AN AUTO ACCIDENT? Y N DATE OF ACCIDENT _____

STATE IN WHICH ACCIDENT OCCURRED _____

RESPONSIBLE PARTY

NAME _____

ADDRESS _____

DATE OF BIRTH _____ DAYTIME PHONE _____

PLACE OF EMPLOYMENT _____

INSURANCE

PRIMARY INSURANCE: _____ NAME OF INSURED: _____

INSURED DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____ NAME OF INSURED: _____

INSURED DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

ID NUMBER: _____ GROUP NUMBER: _____

WORKERS COMPENSATION PATIENTS

CLAIM NUMBER _____ DATE OF INJURY _____

NAME OF EMPLOYER AT TIME OF INJURY? _____

ADDRESS OF EMPLOYER IF THEY ARE SELF INSURED _____

I agree to pay medical costs in the event of failure to prosecute the claim for Worker's Compensation or if the compensation claim is disallowed.

SIGNATURE OF INJURED WORKER _____ DATE _____

PATIENT MEDICAL HISTORY

Tell Us About You:

Name: _____

Why were you referred to physical therapy? Please describe how and when your injury occurred.

_____

_____

What do you want to accomplish from therapy? _____

In the last year, have you undergone any surgical procedures? ☐ YES ☐ NO

In the last year, have you been admitted to a hospital? ☐ YES ☐ NO

What was the condition/surgery? _____

Have you received any physical therapy treatment during the past year? ☐ YES ☐ NO

If yes, for what condition? _____ Where? _____

Have you fallen in the past 12 months? ☐ YES ☐ NO If yes, number of times: _____

If you have fallen in the past 12 months, how did you fall? _____

If you fell did you injure yourself and what was the injury? _____

Tell Us About Your Activities at Work and Home...

Occupation: _____

Hobbies/Sports & Exercise: _____

At the present time, what are the most difficult tasks for you to perform? _____

At WORK: _____

At HOME: _____

Have You Been Concerned With Any of the Following:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Pacemaker	☐	☐	Exposure/Treatment TB	☐	☐
Heart Condition	☐	☐	Seizures	☐	☐	Cough for > 2 weeks	☐	☐
Numbness	☐	☐	Cancer	☐	☐	Fever for > 2 weeks	☐	☐
Neurological	☐	☐	Skin	☐	☐	Unexplained Weight Loss	☐	☐
Diabetes	☐	☐	Weight	☐	☐	Pregnancy	☐	☐
Dizziness	☐	☐	Bladder Control	☐	☐	Digestion	☐	☐
Mental Health	☐	☐	Bowel Control	☐	☐	Immune System	☐	☐

Circle any special tests related to your injury/condition:

CT-scan EMG ECG MRI X-Rays Tilt Table VNG Bone Scan

Please list your medications (include dosage): _____

_____

Patient/Guardian Signature: _____ Date: _____

Reviewed with Patient: _____ Date: _____

Therapist Signature

*Quick*DASH

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

*Quick*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 *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

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

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 <u>not</u> be calculated if there are any missing items.

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