THIES HAND THERAPY

Patient Health History

Patient Name: | Preferred Name: | Date:

Date Of Birth: | SSN: | Phone Number: | Height/ Weight:

Address: | City/State/Zip:

Email Address: | Body Part:

Referring Physician: | Date Of Injury: | Date Of Surgery: | Date Of Next Follow-Up Appt.:

Please List The Details Of What Happened To Result In Current Situation:

Please Rate Your Current Pain: ☐ 0 (No Pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (ER Visit)

Please Rate Your Pain At Its Worse: ☐ 0 (No Pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (ER Visit)

Please List What Type Of Activities Or Movements Intensify Your Pain:

Please Check Any Of The Following Diagnostics You Have Had Specific To Your Current Injury:

☐ X-Rays ☐ CT Scan ☐ MRI ☐ EMG Nerve Studies ☐ Injections

Is Your Injury A Result Of An Auto Accident Or A Work-Related Injury? ☐ Yes ☐ No

Have You Had Two Or More Falls In The Past Year? ☐ Yes ☐ No If Yes, Did It Result In An Injury? ☐ Yes ☐ No

Are You Allergic To Latex? ☐ Yes ☐ No

Please Check Any Symptoms/Conditions You Are Currently Experiencing Or Have Experienced In The Past:

- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Fibromyalgia
- ☐ Fracture/Suspected Fracture
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Huntington's
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury

Other:

Please Check Any Surgical Procedures You Have Had In The Past As It Will Be Considered In Your Treatment Plan:

- ☐ Joint Replacements
- ☐ Orthopedic Surgery
- ☐ Heart Surgery
- ☐ Fracture Reductions
- ☐ Joint Manipulations
- ☐ Spinal Surgery

Other:

The Above Information I Have Provided Is Complete, True And Correct To The Best Of My Knowledge.

Patient/Guardian Signature: | Date:

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Patient Medication List

Please List The Medications You Are Currently Taking:

Patient Name:

	Medication	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Patient Signature: **Date:**

Therapist Signature: **Date:**

Therapist Signature: **Date:**

Therapist Signature: **Date:**

Therapist Signature: **Date:**

Patient Information and Consent to Treat

Thank you for choosing Thies Hand Therapy as your therapy partner. Please carefully read each section below, sign, initial and date at the bottom. Our team is here to assist you if you have any questions.

CONSENT FOR CARE AND TREATMENT: I hereby agree and give my consent to Thies Hand Therapy to provide the appropriate rehabilitative care and treatment, as considered necessary to attend to the betterment of the physical condition. All procedures will be thoroughly explained so I understand the benefits and risks to all interventions, and that I hold the final judgment in such matters (if guardian, on behalf of patient).

Patient Name:		If under 18, Parent/Guardian Name:	
Relationship to Patient:		Parent/Guardian Date of Birth:	
Parent/Guardian Phone Number:		In case of Emergency Contact Name:	
In case of Emergency Contact Phone Number:			
Patient/Guardian Signature:			

NOTICE OF PRIVACY PRACTICES: Thies Hand Therapy is required by law to protect the privacy of your personal health information and provide you a Notice of Privacy Practices. Thies Hand Therapy uses and discloses your personal health information mainly for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care provided. Thies Hand Therapy may also disclose your personal health information without your prior authorization for public health purposes, auditing purposes, emergencies and when required by law. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

PATIENT FINANCIAL RESPONSIBILITY:

- Thies Hand Therapy is not responsible for any misquoted benefit verification information. Your insurance provider will be contacted in order to verify your benefits as accurately as possible. Please inform our team immediately of any changes to your personal information and/or health insurance information so that your claims will process promptly and fully. ***Initial:*** _____

- I understand that verification of my insurance benefits is not a guarantee of payments, and that the insurance company determines benefit payments. ***Initial:*** _____

- I acknowledge that I am responsible for understanding the terms of my insurance plan, and I am able to contact my insurance provider for further details on coverage for my care. ***Initial:*** _____

- It can take 4 weeks or more for the insurance company to process your claims. I authorize Thies Hand Therapy to bill my health insurance on my behalf and I thereby assign all medical benefits to Thies Hand Therapy. ***Initial:*** _____

- I understand and acknowledge that I am financially responsible for payment of services provided to me and that I may be asked to pay at the time of service, whether I am using insurance or not. This includes, but is not limited to co-payments, coinsurance, and deductibles that are not covered by my health insurance. ***Initial:*** _____

- I understand that a **$25 cancellation/no show fee** will be added to my balance if I do not notify the clinic that I am unable to keep my appointment 24 hours prior to the scheduled time. ***Initial:*** _____

Patient Information and Consent to Treat

PATIENT FINANCIAL RESPONSIBILITY (continued):

- I understand that I will receive a statement for all unpaid services if I do not pay at the time of service. If I fail to pay my account balance in full after three final statements, I understand that my account may be referred to a collection agency. ***Initial:*** _____

- Therapy Supply Fees: Your treatment plan prescribed to you by your therapist is designed to meet your personal therapy goals. There may be therapy supplies incorporated into your treatment plan that are not covered by your insurance. Your therapist will discuss these items with you prior to implementing them into your care so you understand the benefits and the cost of the supply in regards to your treatment goals. These types of supplies include, but not limited to: Thera Putty, Exercise Band, Mini Massager or Coban. ***Initial:*** _____

WORKERS' COMPENSATION PATIENTS: We are required to inform your Workers' Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

Photography Agreement:I understand during my treatment filming, taking pictures, or going 'live' on social media of my treatment, or other patients will be prohibited to preserve the privacy of patients without consent from clinic director.

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY: I understand that authorized personnel (including my occupational/hand therapist) from Thies Hand Therapy may communicate with me regarding scheduling/appointments, the treatment provided, home exercise programs, and educational/informative content as it relates to my condition. I understand that my protected health information (PHI) will not be communicated electronically, unless requested by myself. I have the opportunity to opt-out of future communications.

Would you like to receive email appointment reminders: Yes ☐ No ☐

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document:

Printed Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

THIES
HAND THERAPY

THE FOLLOWING IS A STANDARDIZED QUESTIONNAIRE REGARDING YOUR AFFECTED HAND/ARM.

PLEASE ANSWER THE QUESTIONS BASED ON YOUR AFFECTED HAND/ARM AND THE FUNCTION IT WOULD TAKE TO PERFORM THE EXERCISE RATHER THAN THE EXERCISE ITSELF. THIS IS WHETHER IT'S YOUR DOMINANT OR NON-DOMINANT HAND/ARM.

IF YOU HAVE NOT TRIED PERFORMING A SPECIFIC "MOTION", GIVE YOUR BEST GUESS.

YOU MAY LEAVE UP TO 3 QUESTIONS UNANSWERED.

Ex. PUSH OPEN A HEAVY DOOR

ANYTHING WEIGHT BEARING RELATED, GETTING UP OFF THE FLOOR, GETTING UP OFF A CHAIR.

Disabilities of the Arm, Shoulder and Hand

Print 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

Print Name: _____ Date: _____

	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 = ____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.