

APEX HAND THERAPY

Workers' Compensation - Patient Registration Form

PLEASE PRINT LEGIBLY & FILL FORM COMPLETELY

PATIENT DEMOGRAPHIC INFORMATION	LAST NAME	FIRST NAME	MIDDLE NAME	
	SOCIAL SECURITY NUMBER (SSN)	DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		OCCUPATION	
	HOME - STREET NAME & NUMBER		CITY, STATE & ZIP CODE	
	EMPLOYER NAME		EMPLOYER ADDRESS	

PATIENT CONTACT INFORMATION	PHONE NUMBERS		
	HOME: () -	CELL: () -	
	WORK: () -	OTHER: () -	
	- E-MAIL ADDRESS IS REQUIRED AS STATEMENTS WILL BE EITHER E-MAILED &/OR TEXTED.		
	- THERE WILL BE A \$5 FEE FOR EACH MAILED STATEMENT.		
E-Mail for Reminders and Statements/Statement Links:			
Number for Text Reminders and Statement Links:			

EMERGENCY CONTACT INFORMATION	NAME	RELATIONSHIP	
	PHONE NUMBERS		
	HOME: () -	CELL: () -	
	WORK: () -	OTHER: () -	
	HOME - STREET NAME & NUMBER		CITY, STATE & ZIP CODE

WORKERS' COMPENSATION INFORMATION	<input type="checkbox"/> NOT APPLICABLE		
	NAME OF WORKERS' COMPENSATION CARRIER		CLAIM NUMBER
	WORKERS' COMPENSATION CARRIER ADDRESS		CITY, STATE & ZIP CODE
	WORKERS' COMP PHONE NUMBER () -		WORKERS' COMP FAX NUMBER () -
	ADJUSTER'S NAME	PHONE NUMBER () -	FAX NUMBER () -
	CASE MANAGER'S NAME	PHONE NUMBER () -	FAX NUMBER () -
	EMPLOYER AT THE TIME OF INJURY		CONTACT PERSON NAME
	CONTACT PERSON - PHONE NUMBER		CONTACT PERSON - FAX NUMBER
	EMPLOYER - STREET NAME & NUMBER		CITY, STATE & ZIP CODE

APEX HAND THERAPY

PATIENT FULL NAME: _____

LITIGATION INFORMATION	ATTORNEY'S NAME (IF A LAWSUIT IS INVOLVED)		ATTORNEY'S OFFICE NAME	
	PHONE NUMBER		FAX NUMBER	
	() -	() -		
	ATTORNEY'S OFFICE – STREET NAME & NUMBER		CITY, STATE & ZIP CODE	

NOTICE TO WORKERS' COMPENSATION PATIENTS

In the event that Workers' Compensation denies your claim and you plan to use your health insurance to pay for your care, be advised that if your health insurance company requires a PCP referral and you have not obtained one, the insurance company can deny payment. If your health insurance company denies payment, you will be responsible for payment in full for the services & equipment provided.

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY

I know and agree that APEX HAND THERAPY is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE

I hereby release, discharge and acquit APEX HAND THERAPY, it's agent's, representatives, Affiliate's, employees, or assigns, of and from any and liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

APPOINTMENT CANCELLATION NOTICE

I understand and acknowledge that Apex Hand Therapy requires 24-hour cancellation notice for appointments and that a \$ 80.00 fee will be charged for arriving late (10 minutes or more), missed appointments and appointments not cancelled or rescheduled 24 hours prior to the scheduled appointment time.

MEDICAL RECORDS

We require a \$ 10.00 service fee + 50 cents per page in addition to signing the medical records release form for faxed medical records.

We require a \$ 15.00 fee in addition to signing the medical records release form for electronic (e-mailed or CD) medical records.

PATIENT RIGHTS & RESPONSIBILITIES

PATIENT HAS THE RIGHT:

- To considerate and respectful service.
- To obtain service without regard to race, creed, national origin, sex, age, disability diagnosis or religious affiliation.
- To confidentiality of all information pertaining to his/her service (subject to applicable law). [Individuals or organizations not involved in the patient's care may not have access to the information without the patient's written consent.]
- To make informed decisions about his/her care.
- To reasonable continuity of care and service.
- To voice grievances without fear of termination of service or other reprisal in the service process.

PATIENT IS RESPONSIBLE:

- To notify of any DME equipment failure or damage.
- To notify us of equipment that is lost or stolen while in their possession..
- To notify any changes concerning their physician.
- To notify any changes including name, address, phone number, employment.
- To know his/her health plan benefits.
- To pay the bills.
- To treat clinic providers, staff and other patients with dignity, respect, and courtesy.

I AUTHORIZE APEX HAND THERAPY TO:

- Leave messages concerning my appointment time at home / work / cell phones.
- Allow my appointment time to be scheduled, cancelled, or rescheduled by my spouse/ _____
- Accept payment or discuss payment arrangements on my account with my spouse/ _____
- Leave messages concerning payment at home / work / cell phones.
- OTHER _____

I have read and understand all of the above policies & disclaimers.

PATIENT NAME _____

PATIENT SIGNATURE

DATE

APEX HAND THERAPY, LLC

Patient Medical History - I

PLEASE PRINT

PATIENT FULL NAME: _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)					
CONDITION	YES	NO	CONDITION	YES	NO
Heart Problems or Angina	<input type="checkbox"/>	<input type="checkbox"/>	Bowel or Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>
Is your blood pressure under control?	<input type="checkbox"/>	<input type="checkbox"/>	Had Chemotherapy or Radiation (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath or Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Infections (Specify)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack or Heart Surgery (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Diseases (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or TIA (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>	Pins, Plates, Screws Implanted (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot or Emboli (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement(s) (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or Swollen Joints (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>
Psychological/Psychiatric Problems (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems or Difficulties (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	OPEN WOUNDS (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or Severe Headaches (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	SURGERIES (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Fainting (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>	OTHER CONDITIONS (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>
Vision or Hearing Problems (Specify Below)	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems or Goiter	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>
Do you Drink Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	OTHER IMPLANTS (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss or Loss of Energy or Weakness	<input type="checkbox"/>	<input type="checkbox"/>	TINGLING (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	NUMBNESS (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Bronchitis or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES (SPECIFY BELOW)	<input type="checkbox"/>	<input type="checkbox"/>
AIDS (HIV)	<input type="checkbox"/>	<input type="checkbox"/>	LATEX ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>

SPECIFY:

LIST ALL MEDICATIONS (BOTH PRESCRIPTION & OVER THE COUNTER)

MEDICATION TYPE	MEDICATION NAME	PILL SIZE (e.g. 5 mg)	DOSAGE
Pain Relievers			
Anti Inflammatory			
Muscle Relaxants			

LIST ALL INPATIENT & OUTPATIENT SURGICAL ADMISSIONS

HOW IS YOUR GENERAL HEALTH?

POOR FAIR GOOD EXCELLENT

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE

APEX HAND THERAPY, LLC

Patient Medical History - II

PLEASE PRINT

PATIENT FULL NAME: _____

REFERRING PHYSICIAN NAME		PHONE NUMBER	HAND DOMINANCE
			<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT
DIAGNOSIS	TYPE OF SURGERY		DATE OF SURGERY
<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Left		
THIS INJURY/ACCIDENT IS RELATED TO:			DATE OF INJURY/ACCIDENT:
<input type="checkbox"/> WORK <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER (SPECIFY)			
ARE YOU CURRENTLY WORKING?		IF YES, DUTY TYPE	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> REGULAR DUTY <input type="checkbox"/> MODIFIED DUTY	
EXTREMITY BEING TREATED			<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT
<input type="checkbox"/> FINGER <input type="checkbox"/> THUMB <input type="checkbox"/> HAND <input type="checkbox"/> WRIST <input type="checkbox"/> FORE ARM <input type="checkbox"/> ELBOW <input type="checkbox"/> ARM <input type="checkbox"/> SHOULDER			
HOW DID YOUR INJURY HAPPEN?			
REASON FOR ATTENDING THERAPY (CHECK ALL THAT APPLY)			
<input type="checkbox"/> JOINT STIFFNESS	<input type="checkbox"/> WEAKNESS	<input type="checkbox"/> PAIN	<input type="checkbox"/> DIFFICULTY IN DAILY ACTIVITIES
PAIN LOCATION	TYPE OF PAIN	RATE PAIN ON A 0 - 10 SCALE	
1-	1-	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
2-	2-		
3-	3-	<input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	
WHAT ACTIVITIES ARE MOST DIFFICULT BECAUSE OF YOUR PROBLEM?			
WHAT ARE YOUR TREATMENT GOALS?			
CONSENT TO TREATMENT			
The above information is accurate to my knowledge.			
My diagnosis, the evaluation findings, the provider recommendations regarding treatment, the expected benefits or goals of treatment and the reasonable alternatives to recommended treatment have all been explained to me; and my questions about care have been answered to my satisfaction.			
I hereby voluntarily consent to receive treatment for my dependent or myself. I understand that a properly credentialed clinician of Apex Hand Therapy, LLC and in accordance with the law will perform my treatment. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I further understand that I may rescind my consent at any time and will be informed of the potential consequences of that decision.			
PATIENT OR LEGAL GUARDIAN SIGNATURE		DATE	THERAPIST SIGNATURE

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, <i>to what extent</i> 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? (<i>circle number</i>)	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.

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 not be calculated if there are any missing items.