MEDICAL INFORMATION

Pertinent medical history:

- ▫ Cardiovascular Disease
- ▫ Cerebral Vascular Accident
- ▫ Current Infection
- ▫ Diabetes Type 1
- ▫ Diabetes Type 2
- ▫ Fibromyalgia
- ▫ Fracture or Suspected Fracture
- ▫ High Blood Pressure
- ▫ History of Cancer
- ▫ Immunosuppression
- ▫ Muscular
- ▫ Osteoarthritis
- ▫ Parkinson's
- ▫ Rheumatoid Arthritis
- ▫ Seizures
- ▫ Traumatic Brain Injury

Other:_____
_____
_____

Height:_____ **Weight:**_____

Current Medications (name, dosage):
_____
_____
_____
_____
_____
_____

Current pain (1-low/10-high)_____ **Pain at best (1-10)**_____ **Pain at worst (1-10)**_____

Do you smoke? If yes, quantity a day:_____

Do you consume alcohol? If yes, quantity a week:_____

_____

WORKERS COMPENSATION

If filing a workers compensation claim, please fill out employer information to the best of your ability

Employer _____ **Claim Number:**_____

_____ _____ _____
Employer Mailing Address **City** **State**

_____ ( ) _____
Zip Code **Phone**

Teton Hand Therapy, Inc.

OUR FINANCIAL POLICY:

Welcome to Teton Hand Therapy, Inc. We are committed to providing you with the best possible care. We strive to take care of you regardless of your family's financial needs. If you have medical insurance, we will be glad to help you receive your maximum allowable benefits. If you do not have medical insurance, our staff will provide you with information regarding your options. The following is a statement of our Financial Policy which we require that you read, agree and sign prior to initiating treatment.

- All patients must complete our "Patient Information Form" before seeing the therapist
- A **15% discount** is offered to self pay patients who pay in full at the time of service
- We accept cash, check, Visa and Mastercard

INSURANCE

We cannot bill your insurance unless you bring in all of your insurance information, including your identification card, remember that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that in some cases, services provided may be considered "non-covered" services and may not be allowed by your insurance company. We suggest that you review your policy in full so that you understand what services will be covered and those that you will be responsible for. If you have questions regarding your specific benefits, please contact your insurance company.

WORKERS COMPENSATION

In the event that our office is unable to verify your Workers Compensation claim, you are financially responsible for your charges. In the event of a denial, our office will attempt to file your charges with your health insurance. If however, your health insurance carrier denies the charges, the balance is your responsibility.

REFERRALS

If your insurance carrier requires a referral, our office will assist you in obtaining that referral. It is your ultimate responsibility to verify that a valid referral is in place.

FINANCIAL HARDSHIP

If you have financial difficulties, please do not hesitate to see us. We have options available to you including a sliding fee scale for qualified applicants. Please let us know of financial problems before you see the therapist so that arrangements can be made.

CANCELLATIONS & NO SHOWS

It is the policy of this office to accommodate our patient's needs and schedules to the best of our ability. For this reason, we ask our patients to please call us to cancel an appointment they cannot keep, even if only a few hours notice can be given. 24 hours notice is preferred because scheduling during the day is made difficult by late cancellations. Please help us to serve you better by keeping scheduled appointments.

I have read and understand the Financial Policy for Teton Hand Therapy, Inc.

_____ _____

PATIENT / GUARANTOR SIGNATURE DATE

PATIENT NAME: _____ DATE: _____

Description: This survey is meant to helpu 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

DASH (Quick DASH)- INITIAL AND FOLLOW UP VISIT

1. Open a tight or new jar
   a. No Difficulty
   b. Mild Difficulty
   c. Moderate Difficulty
   d. Severe Difficulty
   e. Unable

2. Do heavy household chores (e.g., wash walls, floors).
   a. No Difficulty
   b. Mild Difficulty
   c. Moderate Difficulty
   d. Severe Difficulty
   e. Unable

3. Carry a shopping bag or briefcase.
   a. No Difficulty
   b. Mild Difficulty
   c. Moderate Difficulty
   d. Severe Difficulty
   e. Unable

4. Wash your back.
   a. No Difficulty
   b. Mild Difficulty
   c. Moderate Difficulty
   d. Severe Difficulty
   e. Unable

5. Use a knife to cut food.
   a. No Difficulty
   b. Mild Difficulty
   c. Moderate Difficulty
   d. Severe Difficulty
   e. Unable

6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).
   a. No Difficulty
   b. Mild Difficulty
   c. Moderate Difficulty
   d. Severe Difficulty
   e. Unable

7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors, or groups?
   a. Not at all
   b. Slightly
   c. Moderately
   d. Quite a Bit
   e. Extremely

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?
   a. Not Limited at all
   b. Slightly limited
   c. Moderately limited
   d. Very limited
   e. Unable

9. Arm, shoulder or hand pain.
   a. None
   b. Mild
   c. Moderate
   d. Severe
   e. Extreme

10. Tingling (pins and needles) in your arm, shoulder or hand.
   a. None
   b. Mild
   c. Moderate
   d. Severe
   e. Extreme

11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand.
   a. None
   b. Mild
   c. Moderate
   d. Severe Difficulty
   e. So much difficulty that I can't sleep

Office use only: Patient ID#:_____