ONONDAGA PHYSICAL THERAPY
helping you live, work and play better

Registration Form
(Please Print Clearly)

PATIENT INFORMATION

TODAY'S DATE: / / PRIMARY CARE PHYSICIAN:

Patient's Last Name	First	Middle	What would you prefer to be called?

Street Address	City	State	Zip Code

Home Phone	Work Phone (extension)	Cell Phone	Sex	Age	Date of Birth
			□ Male □ Female		/ /

Email Address:	How would you like us to keep in touch with you?
	□ Email □ Postal Mail

Marital Status	Employment Status	Accident?	Date Of Next Physician Appt
□ Single □ Married □ Widowed □ Divorced	□ Full □ Part □ Retired □ Not Employed □ Other	□ None □ Auto □ Work □ Other	/ /

INSURANCE INFORMATION (Please Show Your Insurance Cards)

Primary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

Secondary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

IN CASE OF EMERGENCY

Contact Name	Relationship To Patient	Home Phone	Cell Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Onondaga Physical Therapy, LLC. I understand that I am financially responsible for any balance that is unpaid by my insurance company. I understand Onondaga Physical Therapy will impose a late fee of $25 for any balance that is older than 90 days, unless I have prior payment arrangements. I further authorize Onondaga Physical Therapy, LLC and my insurance company to release any information that is required to process my claims.

I hereby consent to treatment procedures and patient care which in the judgment of my therapist and/or physician may be considered necessary or advisable while I am a patient of Onondaga Physical Therapy, LLC.

I hereby authorize the use or disclosure of my individually identifiable health information as described in the NOTICE OF PRIVACY PRACTICES I received.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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Medical History Form

(Please Print Clearly)

Name:	Date:

Have you EVER been diagnosed as having any of the following conditions?

Yes No Heart Problems	Yes No Epilepsy / Seizures	Yes No Implanted Devices
Yes No High Blood Pressure	Yes No Hearing Loss / Disorder	Yes No Cancer
Yes No Pacemaker	Yes No Eye Disease	Yes No Osteoporosis
Yes No Rheumatoid Arthritis	Yes No Muscular Disease / Disorder	Yes No Depression
Yes No Other Arthritic Condition	Yes No Multiple Sclerosis	Yes No Past Pregnancy
Yes No Stroke	Yes No Tuberculosis	Yes No Currently pregnant
Yes No Lung Disease	Yes No Circulation Problems	Yes No Chemical Dependency
Yes No Asthma	Yes No Hepatitis	Yes No Other:
Yes No Diabetes	Yes No Kidney Disease	

Please list any surgeries or other medical conditions for which you have been treated

Date	Surgery/Injury/Condition	Reason:

List all medications you are currently taking (pills, injections, inhalers, skin patches):

Any additional comments or information you would like us to know:

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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HIPAA Privacy Information

TODAY'S DATE: / /

PATIENT INFORMATION

Patient's Last Name First Name Date of Birth

CONTACT METHODS

Please check the appropriate boxes indicating acceptable ways for us to contact you regarding either your appointment(s) or other medical information. By checking these boxes, you give us permission to contact you and/or leave messages.

Appointment Information	Medical Information
□ Home Phone	□ Home Phone
□ Mobile Phone	□ Mobile Phone
□ Mobile Text**	□ Mobile Text**
□ Work Phone	□ Work Phone
□ With another person:	□ With another person:
□ Send Via Mail	□ Send Via Mail
□ Send Via Email	□ Send Via Email

**Checking the Mobile Phone box will enroll you in Text Message Appointment Reminders. Messages are an automated reminder only and are delivered the night before your appointments with us. Carrier messaging rates apply per your plan.

If you have authorized us to communicate medical or appointment information with another individual, please provide their name and relationship:

Name: _____ Relationship: _____

AGREEMENT INFORMATION

I have read the above information and have authorized Onondaga Physical Therapy to relay appointment or medical information in the manners I have specified above.

x _____

PATIENT SIGNATURE DATE

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Attendance Policy

Onondaga Physical Therapy requires a minimum 24-hour notice when cancelling any appointment

- Cancellations may be submitted via text message or phone call to (315) 635-5000
- It is expected for you to arrive on time to all scheduled appointments. If you arrive more than **10 minutes late,** you will be considered a "no show".
- Text message reminders are a courtesy and should NOT be used as a primary method of tracking your appointments as they are not 100% reliable.

Please be considerate of our other patients - If your **personal or work** schedule might affect your ability to keep your appointment, please don't schedule until you are certain you can keep your time. We do utilize a waiting list so that we can offer cancelled appointment slots to other patients waiting to be treated.

We are sensitive to the fact that an emergency may occur in a rare instance and do offer 1 cancellation per month as a courtesy for these instances.

Late Cancellation (less than 24 hours notice) and No-Show Fees:

- 1st late cancel/No Show per month - Fee Waived
- 2nd late cancel/No Show per episode of care - $25
- 3rd late cancel/No Show per episode of care - $50
- 4th late cancel/No Show per episode of care - $65

(Exceptions may be made for bad weather when schools in our area close or dismiss early as well as travel advisories issued for Onondaga County.)

If you fail to show for an appointment or cancel without speaking to one of us, we will call or text you to remind you of your next appointment. If we do not hear from you by the next morning confirming this appointment, we will **delete all future appointments** opening up opportunities for us to help other patients. Please call to reschedule your appointments.

I agree to abide by the above policy and to pay the above fee PRIOR to my next appointment if I am in violation. I understand these charges will NOT be covered by my insurance company.

X _____

Printed Name **Signature** **Date**

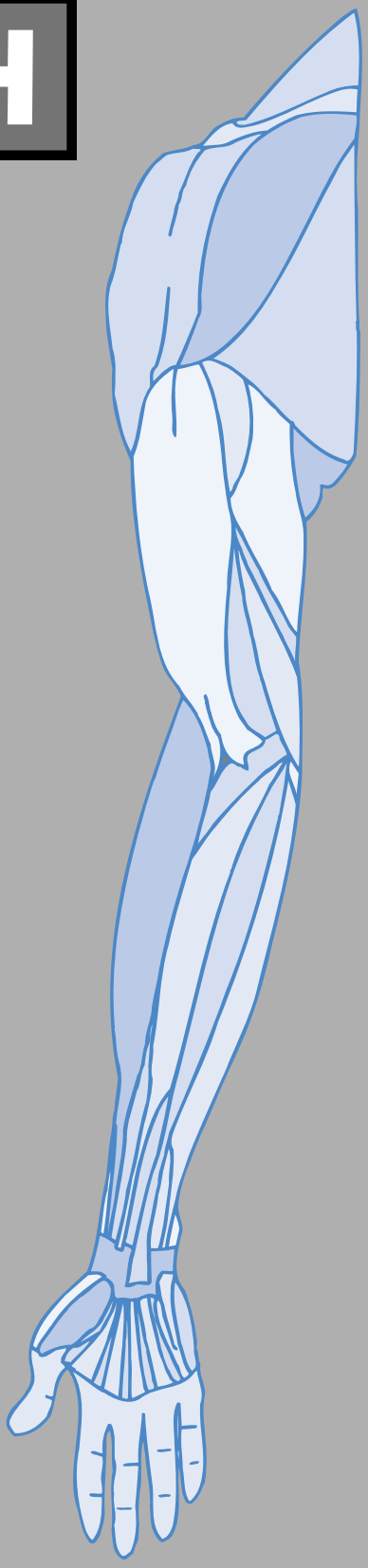
Therapist Reviewed (Initial): _____

Name & DOB:_____ Date:_____

Disabilities of the Arm, Shoulder and Hand

THE DASH

Score: _____



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Disabilities of the Arm, Shoulder and Hand

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

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

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

DISABILITIES OF THE ARM, SHOULDER AND HAND

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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