Outpatient Rehabilitation Department
Medical History Form

Name: _____ Birth Date: _____
Referring Doctor: _____ Primary Care Physician: _____
Phone Number: Home _____ Email: _____
Cell _____

Reason you are attending therapy: _____

Please check any of the following whose care you have been under (past year):
_____Medical Doctor (MD) _____ Psychiatrist/Psychologist
_____Orthopedic Doctor _____ Physical Therapy
_____Dentist _____ Chiropractor
_____Other (Explain) _____

Why have you seen the above? In addition, include any emergency room trips and prior hospitalizations. Fill in dates and Explanation below.
_____
_____
_____

If you have a history of any of the following, please indicate below:

☐ Cancer: What type?	☐ Lymes Disease
☐ Heart Problems	☐ Rheumatoid Arthritis
☐ Pacemaker	☐ Osteoarthritis
☐ High Blood Pressure	☐ Fibromyalgia Syndrome(FMS)
☐ Diabetes	☐ Depression
☐ DVT/blood clots	☐ Thyroid Problems
☐ Circulation problem	☐ Joint Replacement
☐ Osteoporosis	☐ Multiple Sclerosis
☐ Asthma	☐ Seizures
☐ Emphysema/Bronchitis	☐ Epilepsy
☐ Tuberculosis	☐ Stroke
☐ Kidney Disease	☐ Alcoholism, Illicit Drug Use
☐ HIV Disease/AIDS	☐ Hepatitis
☐ Latex Allergy	☐ Gout
☐ Other Allergies: Explain	☐ Other: Explain

During the past month, have you been feeling down, depressed or hopeless? YES NO
During the past month, have you had little interest in doing things? YES NO
Do you feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO
Date of last menstrual period: _____

Please Describe any significant injuries for which you have been treated (including fractures, sprains, etc. and the approximate date off injury.

Date	Injury	Date	Injury

Which of the following OVER-THE-COUNTER medication have you taken in the past week?

Yes	No	Aspirin
Yes	No	Tylenol
Yes	No	Advil/Motrin/Ibuprofen
Yes	No	Laxatives
Yes	No	Decongestant
Yes	No	Antihistamines
Yes	No	Antacid
Yes	No	Vitamins/Mineral supplement
Yes	No	Other

Please list any PRESCRIPTION medication you are currently taking (INCLUDING tablets, capsules, patches, and/or injections).

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

How many caffeinated coffee or caffeine containing beverages do you drink per day? _____
Do you smoke? Yes ____ No ____
If you do smoke, how many cigarettes do you smoke a day? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ___

Have you recently noted:

Yes	No	Unexplained weight loss or weight gain
Yes	No	Nausea/Vomiting
Yes	No	Fatigue
Yes	No	Weakness
Yes	No	Fever/chills/sweats
Yes	No	Numbness/tingling
Yes	No	Dizziness when you stand up
Yes	No	Chest pain
Yes	No	Shortness of breath

Patient signature_____ Date_____

Therapist Signature _____ Date_____

Hackensack UMC Mountainside

1 Bay Avenue
Montclair, NJ 07042

Welcome to the Rehabilitation Department at Hackensack UMC Mountainside. Our highly qualified and motivated staff is here to make your rehabilitation experience beneficial as well as enjoyable. To ensure this, we are providing some simple guidelines to follow:

- Please double check with your insurance company to make sure that we do participate with your plan. Ultimately, you are responsible for any financial obligations that are associated with your insurance.
- If your insurance requires a pre-certification there may be delay in your follow up visit. The rehabilitation department will notify you when the authorization is received.
- If you have a Co-payment, it is required prior to services being rendered.
- If you accumulate three no shows or cancelled appointments you will may discharged for the services you are receiving at the Outpatient Department of Hackensack UMC Mountainside. You will not be permitted to schedule future appointment at this facility without written consent from the Director of Rehabilitation Services.
- Please be prompt with your scheduled appointment so we can maximize your treatment. If you are arriving late, your treatment time is subject to cancellation and rescheduling.
- Please bring or wear proper clothing to make you affected treatment area accessible. We do provide changing rooms with lockers for you convenience.(Please bring your own lock)
- In case of inclement weather, please call ahead of time to confirm your appointment.
- Use of cellular phones is prohibited inside the gym area. Please turn off your cellular phone when you are inside of the gym.
- Anyone who is under the age of 18 in the reception/waiting area unattended. Please make arrangement for your children before coming to Physical Therapy.
- Most importantly, please communicate with your therapist! The more information that is known the better we can help you recover.

By following these simple guidelines, together we can reach your goal in the shortest amount of time.
Thank you again for choosing us as your rehabilitation provider.

Please sign to acknowledge that you have read and understood the guidelines.

_____ _____
Patient Signature Date

_____ _____
Signature of legal Guardian-Health Care Agent, or other personal Representative Date

_____ _____
Witness Signature Date

Hackensack UMC Mountainside
1 Bay Avenue
Montclair, NJ 07042

Insurance Authorization/Pre-certification information

Welcome to the Rehabilitation Department at Hackensack UMC Mountainside. Our staff will make every effort to work with you and your insurance company. However, the following conditions apply:

- Please be advised that some insurance companies require pre-certification/ authorization before starting any physical therapy treatment
- Please follow up with your insurance company to confirm whether you are required to obtain a pre-certification/ authorization
- Please inform your insurance company that all authorizations must be faxed to the Hackensack UMC Mountainside Rehabilitation Department at the following fax number 973-680-7917
- The authorization should include the amount of visits approved by your insurance company and the date span for the visits along with an authorization number
- Pre-certification/ authorization may delay your follow up appointment. To avoid a longer waiting period please contact your insurance company to expedite approval
- After your initial evaluation a member of our staff will fax the appropriate documentation to your insurance company for approval
- You are ultimately responsible for the follow up and ensure that authorization has been granted before starting treatments
- Failure to obtain an authorization from your insurance company will result in you being personally responsible for any financial obligations that are associated with your treatments

By following these guidelines and working together we hope to ensure a positive experience at Hackensack UMC Mountainside. Thank you again for choosing us as your rehabilitation provider!

_____ _____
Patient Signature Date

_____ _____
Signature of legal Guardian-Health Care Agent, or other personal Representative Date

_____ _____
Witness Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature

THE QuickDASH OUTCOME MEASURE

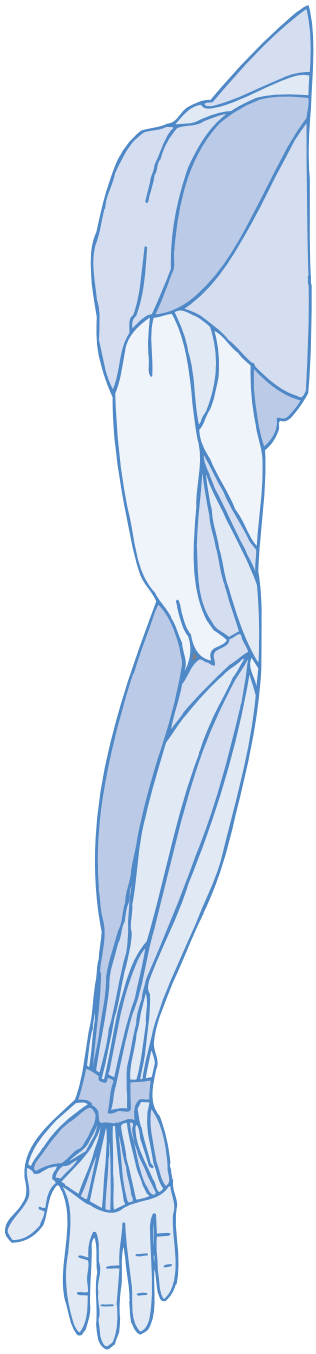
INSTRUCTIONS

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* of 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.



*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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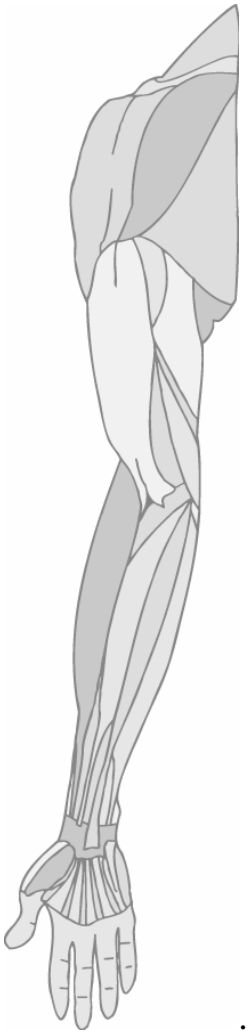
*Quick*DASH
Versión Española (España)



Instrucciones

Este cuestionario le pregunta sobre sus síntomas así como su capacidad para realizar ciertas actividades o tareas

Por favor conteste cada pregunta basándose en su condición o capacidad durante la última semana. Para ello marque un círculo en el número apropiado.

Si usted no tuvo la oportunidad de realizar alguna de las actividades durante la última semana, por favor intente aproximarse a la respuesta que considere que sea la más exacta.

No importa que mano o brazo usa para realizar la actividad; por favor conteste basándose en la habilidad o capacidad y como puede llevar a cabo dicha tarea o actividad.

Spanish (Spain) translation courtesy of Dr. R.S. Rosales, MD, PhD, Institute for Research in Hand Surgery, GECOT, Unidad de Cirugía de La Mano y Microcirugía, Tenerife, Spain

Por favor puntúe su habilidad o capacidad para realizar las siguientes actividades durante la última semana. Para ello marque con un circulo el número apropiado para cada respuesta.

	Ninguna dificultad	Dificultad leve	Dificultad moderada	Mucha dificultad	Imposible de realizar
1. -Abrir un bote de cristal nuevo	1	2	3	4	5
2.-Realizar tareas duras de la casa (p. ej. fregar el piso, limpiar paredes, etc.	1	2	3	4	5
3.-Cargar una bolsa del supermercado o un maletín.	1	2	3	4	5
4.-Lavarse la espalda	1	2	3	4	5
5.-Usar un cuchillo para cortar la comida	1	2	3	4	5
6.-Actividades de entretenimiento que requieren algo de esfuerzo o impacto para su brazo, hombro o mano (p. ej. golf, martillear, tenis o a la petanca)	1	2	3	4	5
	No, para nada	Un poco	Regular	Bastante	Mucho
7.- Durante la última semana, ¿ su problema en el hombro, brazo o mano ha interferido con sus actividades sociales normales con la familia, sus amigos, vecinos o grupos?	1	2	3	4	5

	No para nada	Un poco	Regular	Bastante limitado	Imposible de realizar
8.- Durante la última semana, ¿ha tenido usted dificultad para realizar su trabajo u otras actividades cotidianas debido a su problema en el brazo, hombro o mano?	1	2	3	4	5

Por favor ponga puntuación a la gravedad o severidad de los siguientes síntomas

	Ninguno	Leve	Moderado	Grave	Muy grave
9.- Dolor en el brazo, hombro o mano.	1	2	3	4	5
10.-Sensación de calambres (hormigueos y alfilerazos) en su brazo hombro o mano.	1	2	3	4	5

	No	Leve	Moderada	Grave	Dificultad extrema que me impedía dormir
11.- Durante la última semana, ¿cuanta dificultad ha tenido para dormir debido a dolor en el brazo, hombro o mano?.	1	2	3	4	5

Cálculo de la puntuación del "Quick Dash" (Discapacidad/Síntomas) = ([(suma de n respuestas)/n] -1) x 25, donde n es igual al número de respuestas completadas. La puntuación del "Quick Dash" no puede ser calculada si hay más de 1 ítem sin contestar.

Módulo de Trabajo (Opcional)

Las siguientes preguntas se refieren al impacto que tiene su problema del brazo, hombro o mano en su capacidad para trabajar (incluyendo las tareas de la casa sí ese es su trabajo principal)

Por favor, indique cuál es su trabajo/ocupación: _____

Yo no trabajo (usted puede pasar por alto esta sección) .

Marque con un círculo el número que describa mejor su capacidad física en la semana pasada. **¿Tuvo usted alguna dificultad...**

	Ninguna dificultad	Dificultad leve	Dificultad moderada	Mucha dificultad	Imposible
1. para usar su técnica habitual para su trabajo?	**1**	**2**	**3**	**4**	**5**
2. para hacer su trabajo habitual debido al dolor del hombro, brazo o mano?	**1**	**2**	**3**	**4**	**5**
3. para realizar su trabajo tan bien como le gustaría?	**1**	**2**	**3**	**4**	**5**
4. para emplear la cantidad habitual de tiempo en su trabajo?	**1**	**2**	**3**	**4**	**5**

Actividades especiales deportes/músicos (Opcional)

Las preguntas siguientes hacen referencia al impacto que tiene su problema en el brazo, hombro o mano para tocar su instrumento musical, practicar su deporte, o ambos. Si usted practica más de un deporte o toca más de un instrumento (o hace ambas cosas), por favor conteste con respecto a la actividad que sea más importante para usted. Por favor, indique el deporte o instrumento que sea más importante para usted.

¿Tuvo alguna dificultad.:

	Ninguna	Dificultad	Dificultad	Mucha	Imposible

	dificultad	leve	moderada	dificultad	
para usar su técnica habitual al tocar su instrumento o practicar su deporte?	1	2	3	4	5
para tocar su instrumento habitual o practicar su deporte debido a dolor en el brazo, hombro o mano ?	1	2	3	4	5
para tocar su instrumento o practicar su deporte tan bien como le gustaría?	1	2	3	4	5
para emplear la cantidad de tiempo habitual para tocar su instrumento o practicar su deporte?	1	2	3	4	5

Puntuación de los Módulos Opcionales: Sumar los valores asignados a cada respuesta en cada módulo; divídalo por 4 (número de ítems en cada módulo); restar 1; multiplique por 25.. La puntuación de un módulo opcional no puede ser calculada si hay algún ítem sin contestar.