CAPITAL PHYSICAL THERAPY, PLLC

Wrist and Hand Initial Questionnaire

Your Name: _____ Date: _____

Referring Physician: _____ Sex: _____ Age: _____ Weight: _____

Sports/Hobbies: _____

Occupation: _____ Does occupation include manual labor: _____

Information in regards to your injury

Date of injury: _____ Date of surgery (if indicated): _____

What happened? _____

Is this your first episode of wrist/hand injury? _____

Previous treatment for this injury included: _____

Do you have a history of neck injury? _____

Does your injury limit self care or the care to others? _____

Was your hand/wrist functioning normally before the injury? (if not, please explain) _____

Past Medical History

	Yes	No	N/A	
1. Arthritis?	☐	☐	☐	Where? _____
2. Any unexplained weight loss?	☐	☐	☐	
3. Any weight gain?	☐	☐	☐	
4. Headaches or Migraine?	☐	☐	☐	
5. Diabetes?	☐	☐	☐	
6. Do you smoke?	☐	☐	☐	
7. History of Cancer?	☐	☐	☐	Where? _____
8. History of Cancer in the Family?	☐	☐	☐	
9. Intestinal Problems?	☐	☐	☐	
10. Carpeltunnel surgery?	☐	☐	☐	
11. Any implanted devices such as a pacemaker or an artificial joint?	☐	☐	☐	Where? _____
12. Do you suffer from depression due to your illness?	☐	☐	☐	
13. Psychiatric illness?	☐	☐	☐	
14. Pregnancy?	☐	☐	☐	
15. High/low blood pressure?	☐	☐	☐	
16. Lung disease?	☐	☐	☐	
17. History of neck pain?	☐	☐	☐	
18 Heart disease?	☐	☐	☐	
19.Decreased circulation in forearm/hand	☐	☐	☐	
20. Arteriosclerosis	☐	☐	☐	

21. Other Illness: _____

Information in regards to your medication

List your medications here

_____

_____

_____

Information in regards to your pain

0= Pain free 2= Discomfort 4-6= Moderate 8= Severe 10= Excruciating

1. Please circle the **worst** pain you have experienced during the past week: 0 2 4 6 8 10

2. Please circle your **current** pain: 0 2 4 6 8 10

3. Please circle the **least** pain you have experienced during the past week: 0 2 4 6 8 10

4. Please circle the **duration** of your pain: 1= Brief 2= Intermittent 3= Constant

5. Please circle your **medication** use: 1= None 2= Occasional/as needed 3= Constant

a. Prescription b. Over the counter

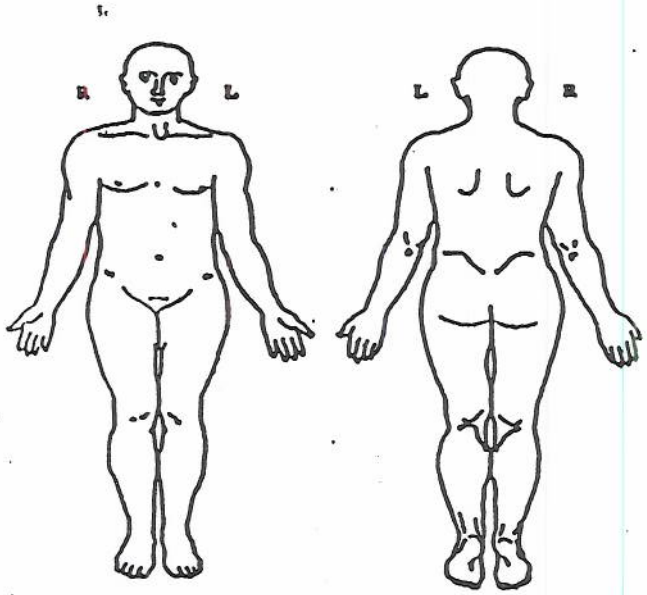
6. Have you experienced any **numbness and tingling** this past week: 1=Yes 2=No If yes where? _____

7. Have you experienced any **night pain** this past week: 1=Yes 2=No If yes where? _____

The location of your pain and other symptoms

Please mark your pain on the diagram on the right:

✱= Pain
◆= Numbness/Tingling
↕ = Shooting pain
↔= Pulsing/beating or throbbing pain



Information in regards to your daily functioning (please circle)

1. Able without difficulty 2. Able with some limitation 3. Difficult 4. Very difficult 5. Unable

With the injured/wrist can you?

1. Make a closed fist?	1	2	3	4	5	N/A
2. Write legibly?	1	2	3	4	5	N/A
3. Fasten your seatbelt?	1	2	3	4	5	N/A
4. Start a car?	1	2	3	4	5	N/A
5. Brush teeth?	1	2	3	4	5	N/A
6. Get dressed?	1	2	3	4	5	N/A
7. Comb hair?	1	2	3	4	5	N/A
8. Eat with involved side?	1	2	3	4	5	N/A
9.Wipe after a bowel movement?	1	2	3	4	5	N/A
10. Lift a filled cup or glass?	1	2	3	4	5	N/A
11. Lift a filled full-size pan from the stove?	1	2	3	4	5	N/A
12. Lift groceries into a shopping cart?	1	2	3	4	5	N/A
13. Prepare your own meal?	1	2	3	4	5	N/A
14. Perform work duties with ease?	1	2	3	4	5	N/A

Which activities ease your pain? _____
Which activities increase your pain? _____
Since the injury the pain has become? Worse The same Better

Information in regards to special tests

Did you undergo any of the following tests? (1=Yes, 2=No,3=Don't know)

M.R.I: _____ Bone Scan: _____ Do you know the outcome of these studies?
Cat Scan: _____ E.M.G _____ _____
X-ray: _____ _____

Signature: _____ **Date:** _____

CAPITAL PHYSICAL THERAPY, PLLC

PATIENT INFORMATION

Date:_____

Patient:_____

Address:_____

_____

City State Zip

Home phone:_____

Male___Female___Age___D.O.B._____

Married___Single___Widowed_____

Patient Social Security:_____

Occupation:_____

Employer:_____

Spouse's Name:_____

Birthdate:_____

Occupation:_____

Spouse's employer:_____

Family Physician:_____

Referring Physician:_____

Referring Physician's phone:_____

IN CASE OF EMERGENCY CONTACT:

Name:_____

Relationship:_____

Phone:_____

INSURANCE INFORMATION

Responsible party:_____
Relationship to patient:_____
Birthdate:_____
Primary Insurance:_____
Subscriber's Number:_____
Group Number:_____

Secondary Insurance:_____
Subscribers Name:_____
Birthdate:_____
Relationship to patient:_____
Subscribers Number:_____
Group Number:_____

Auto Insurance:_____
Claim Number:_____
Claims Adjuster:_____

Workman's Comp. Case #:_____
Case Worker:_____

Release of Information and Assignment of Benefits:

I hereby give my consent for an evaluation and treatment by Capital Physical Therapy, PLLC staff. I give permission for Capital Physical Therapy, PLLC to obtain my medical records. I authorize the release of any medical or other information relating to all claims for benefits submitted on my behalf. I permit a copy of this authorization to be used in place of the original. I request payment to be made on my behalf to Capital Physical Therapy, PLLC.

_____
Patient's Signature

_____
Signature of Parent/Guardian (if patient is a minor)

CAPITAL PHYSICAL THERAPY, PLLC

FINANCIAL POLICY

THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY THAT ALL PATIENTS ARE REQUIRED TO READ AND SIGN BEFORE TREATMENT.

REGARDING INSURANCE:

AS A COURTESY TO OUR PATIENTS WE WILL GLADLY BILL YOUR INSURANCE COMPANY.PROVIDED WE HAVE COMPLETE PATIENT AND INSURANCE INFORMATION. WE DO PARTICIPATE WITH MEDICARE AND OTHER PRIVATE INSURANCES. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THIS CONTRACT. THEREFORE, UNDER ANY CIRCUMSTANCES, YOU THE PATIENT ASSUME FINANCIAL RESPONSIBILITY FOR YOUR ACCOUNT.

DEDUCTABLES AND CO-PAYS

UPON YOUR FIRST VISIT TO CAPITAL PHYSICAL THERAPY, PLLC. OUR PATIENT ACCOUNTS MANAGER WILL VERIFY YOUR COVERAGE AND ANY DEDUCTABLE AND CO-PAYMENT REQUIREMENTS. PLEASE UNDERSTANDING THAT INSURANCE VERIFICATION IS NOT A **GUARANTEE OF PAYMENT** AND SOME OR ALL OF YOUR TREATMENT MAY NOT BE COVERED UNDER YOUR POLICY. IT IS OUR POLICY TO COLLECT ALL DEDUCTABLE AND CO-PAYMENT AMOUNTS AT THE TIME OF SERVICE. FOR YOUR CONVIENCE WE ACCEPT PERSONAL CHECK FOR PAYMENT. PLEASE NOTE THAT FINANCE CHARGES IN THE AMOUNT OF 18% (1.5% MONTHLY) WILL BE ASSESED ON UNPAID BALANCES AFTER 30 DAYS.

ATTENDANCE:

PLEASE BE AWARE THAT ATTENDANCE IS IMPORTANT THEREFORE, IF THREE ABSENCES OCCUR WITH OUT A CALL TO INFORM US OF THE REASON FOR NOT ATTENDING THE SESSION IT WILL BE OUR UNDERSTANDING THAT YOU ARE NOT INTERESTED IN ATTENDING PHYSICAL THERAPY ANY LONGER. IF YOU WISH TO RESUME AGAIN A NEW REFERRAL SCRIPT WILL BE NEEDED FROM REFERRING DOCTOR AT TIME OF RE-START VISIT.

THANK YOU FOR READING AND UNDERSTANDING OUR FINANCIAL POLICY. IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE ASK TO SPEAK WITH OUR OFFICE COODINATOR.

I UNDERSTAND AND AGREE TO THE ABOVE STATED FINANCIAL POLICY.

X_____ **DATE:** _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY