Instructions for Completing Forms

Dear Patient,

Please call one of our three convenient locations to schedule your first appointment: ***Georgetown Therapy IH-35*** (512-863-7761), ***Georgetown Therapy at Austin Avenue*** (512-763-4500), or ***Georgetown Therapy - Liberty Hill*** (512-778-6700).

Please print and complete the following forms prior to your first appointment. Please respond to each request for information:

FORMS

Pg 1.	Instructions for Completing Forms	
Pg. 2.	Registration	**Print and Complete**
Pg. 3	Insurance	**Print and Complete**
Pg. 4	Vision and Mission	**Print for Your Information**
Pg. 5&6	Privacy	**Print for Your Information**
Pg. 7&8	Health Questionnaire	**Print and Complete**

From the following forms below, please choose the one that best represents the part of your body we are going to treat. Print that form, and complete the requested information.

Pg. 9	Back Index
Pg. 10	Lower Extremity Functional Scale
Pg. 11	Neck Index
Pg. 12	Quick Dash (Arm, Shoulder, Hand)
Pg. 13	Quick Dash (Arm, Shoulder, Hand if it affects your work or sports)

PLEASE BRING ALL OF THE COMPLETED FORMS WITH YOU TO YOUR FIRST VISIT. THANK YOU!

Georgetown Therapy IH-35
204 S. IH 35, Ste 203
Georgetown, Texas 78628
512-863-7761

Austin Avenue Clinic
3201 S. Austin Avenue, Ste. 170
Georgetown, Texas 78626
512-763-4500

Liberty Hill Clinic
13740 State Hwy 29, Ste 3
Liberty Hill, Texas 78642
512-778-6700

GEORGETOWN
Sports Ortho Spine
PHYSICAL THERAPY CENTERS

PATIENT INFORMATION — EMAIL ADDRESS: ____________________

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	

Chose Clinic Because/ Referred to Clinic By ☐ Dr.: ☐ Insurance Plan ☐ Family ☐ Friend

☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:

WORK INFORMATION

Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:

Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto : ☐ Labor & Industries:

Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):

Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Practice Name. I understand that I am financially responsible for any balance. I also authorize ____________________________ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

GEORGETOWN THERAPY
PATIENT REGISTRATION AND INFORMATION

Georgetown IH-35 • Georgetown at Austin Avenue • Liberty Hill

Name___________________________________ Date__________________________

PATIENT REGISTRATION AND INFORMATION
PAGE 2

Welcome to Georgetown Therapy. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Financial Policy

Your insurance coverage is an agreement between you and your insurance company. As a courtesy to our patients, we will contact your insurance company to obtain benefit and eligibility information as well as file claims for you. However, this is not a guarantee of payment, and all claims are subject to plan provisions under your policy. It is your responsibility to remit payment for charges not covered by your insurance company. Payment for co-pay and/or deductible is/are expected at the time services are rendered, unless prior arrangements have been made with our Business Office Manager.

Cancellation Policy

Consistency of treatment by following a plan of care, as outlined by your physical therapist and physician, is critical in order to achieve a successful outcome. We understand that unexpected situations arise that could cause you to be unable to attend your scheduled appointment. We ask that you contact our office 24 hours in advance or as soon as possible to cancel and/or reschedule appointments. Patients who routinely cancel and/or no-show for appointments will incur a $25 charge for each missed appointment.

Consent to Release Information

I authorize the release of any medical information (including records) necessary to process my insurance claims. I authorize and request payment of medical benefits be released directly to Georgetown Therapy. I agree that this authorization will cover all medical services rendered by Georgetown Therapy. My authorization shall remain in effect until I revoke such authorization by means of written notice to provider of services. I permit a coy of this authorization to be used in place of the original.

Benefits and Eligibility Verification

The staff of Georgetown Therapy have explained to me what deductible, and/or co-pay is my responsibility as explained to Georgetown Therapy by my insurance company. I understand that this information is not a guarantee of payment by my insurance company, nor is it a guarantee of what deductible, percentage, and/or copay is my responsibility.

My signature below indicates that I have received a copy of privacy information, read and understand all of the above and give consent to be evaluated and treated by Georgetown Therapy.

____ ________________________________

Signature (Patient or Representative) Date

GEORGETOWN THERAPY

VISION STATEMENT

We are the community's premier provider of rehabilitation and wellness programs. We are committed to improving the health and wellbeing of those we serve, while providing an excellent work environment for our valued employees, and continuously enhancing our facilities, resources, and quality of care.

MISSION STATEMENT

We, the staff of Georgetown Therapy, assume ownership and enactment of our vision by:

Serving **our Lord, our family, our customers, and our community.**

Creating **innovative wellness programs and treatment protocols.**

Understanding **what our customers need and want.**

Providing **a fun, dynamic, and challenging work atmosphere, which empowers our employees to achieve both their personal and professional goals.**

Assuring **that each personal, business, and personnel decision made is held to the highest degree of integrity and accountability.**

Reinvesting **resources into facilities, programs, and professional development.**

January, 2007

GEORGETOWN THERAPY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1) Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law
The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.
Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact

If you would like more information about our privacy practices, two copies are in our waiting room.

Source: American Physical Therapy Association.

GEORGETOWN THERAPY
PATIENT HEALTH QUESTIONNAIRE

Patient Name____**Height**_____**Weight**_____**DOB**________**Age**________
Referring Physician_____________________________**Primary Physician**____

1. **Describe your symptoms** ____
____
   a. When did your symptoms start? ____
   b. How did your symptoms begin? ____
   c. Symptoms improve when… ____
   d. Symptoms worsen when… ____

2. **Who have you seen for your symptoms?** ①No one ③Medical Doctor ⑤Other ②Chiropractor ④Physical Therapist
   a. What treatment did you receive and when? ____
   b. What tests have you had for your symptoms and when were they performed? ①X-rays date_____ ③CT Scan date_____ ②MRI date_____ ④Other date_____
   Results___________________________________

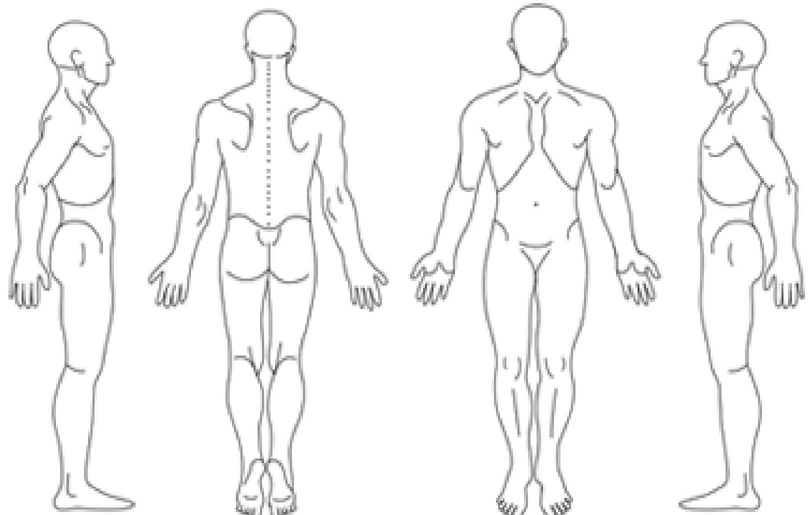
3. **Have you had similar symptoms in the past?** ①Yes ②No
   a. If you have received treatment in the past for the same or similar symptoms, which did you see? ① This Office ③ Medical Doctor ⑤ Other ② Chiropractor ④ Physical Therapist
   b. Injections for pain? Date(s)_____________________
   c. Did you recover?_______________________________

4 . **Related to this condition, have you had?**
   a. Hospitalizations (recent-date-where)____
   b. Surgeries: (recent and/or related)____
   c. Current Medications ____
   (Include over the counter) ____
   d. Allergies to any medications? ____
   Allergic to latex? yes__ no__

5. **In general would you say your overall health right now is…**
   ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

IF YOU DO NOT HAVE PAIN, SKIP TO QUESTION #9

6. **How often do you experience your symptoms? Indicate where you have pain or other symptoms**
   ① Constantly (76-100% of the day)
   ② Frequently (51-75% of the day)
   ③ Occasionally (26-50% of the day)
   ④ Intermittently (0-25% of the day)
   When ___am ___pm ___bedtime



7. **What describes the nature of your symptom**
   ① Sharp ④ Shooting
   ② Dull ache ⑤ Burning
   ③ Numb ⑥ Tingling

8. **How are your symptoms changing?**
   ① Getting Better
   ② Not Changing
   ③ Getting Worse

9. During the past 4 weeks: none — unbearable

a. Indicate the average intensity of your symptoms ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. How much has pain interfered with your normal work (including both work outside the home and housework)

①Not at all ②A little bit ③Moderately ④Quite a bit ⑤Extremely

10. During the past 4 weeks, how frequently has your condition interfered with your social/recreation activity?

①All of the time ②Most of the time ③Some of the time ④A little of the time ⑤None of the time

11. What is your occupation?

①Professional Executive ④Laborer ⑦Retired
②White Collar/Secretarial ⑤Homemaker ⑧Other
③Tradesperson ⑥FT Student

____

a) If you are not retired, a homemaker, or a student, what is your current work status

① Full-time ② Self-Employed ⑤ Off Work
②Part-time ④ Unemployed ⑥ Other

12. Is your condition or injury work related? ①Yes ②No
Auto Accident? ①Yes ②No

13. What are your expectations of Physical Therapy?____

Please check if you have experienced any of these in the past two (2) months.	**Please check if you have ever had any of the following:**
O Pregnant (currently)	○ Arthritis: Osteoarthritis Rheumatoid
O Significant weight loss/gain	○ Balance Difficulties
O Pain at night	○ Cancer
O Bowel/bladder problems	○ Diabetes
O Pain when you lie down	○ Heart Problems
O Pain when you cough/sneeze	○ High Blood Pressure
O Numbness in arms or legs	○ Metal Implants
O Pins/needles/tingling in arms or legs	○Osteoporosis
O Frequent dizziness	○ Stroke
O Frequent headaches	○ Other________________________
O Leg cramps	
O Other________________________	

Patient Signature______________________________ **Date**______________________________

++

COMPLETE ONLY IF WE ARE TREATING THIS PART OF YOUR BODY

GEORGETOWN THERAPY

QUICK DASH (Arm, Shoulder, Hand)

Patient Name_______________________________Date________________________

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 DFFICULTY	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, neighbors 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, 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 pat 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

QuickDASH DISABILITY SYMPTOM SCORE = $\left(\frac{\text{Sum of n responses}}{n}\right) - 1 \times 25$, where n is equal to the number of completed responses.

Current Score ___________ **Prior Score** __________
Date_______________

A QuickDASH score may not be calculated if there is greater than 1 missing item.

COMPLETE ONLY IF WE ARE TREATING THIS PART OF YOUR BODY

GEORGETOWN THERAPY

Neck Index

Patient Name____Date_______________________

This questionnaire will you give your therapist information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark only the one that most closely describes your problem.

Pain Intensity
⓪ I have no pain at the moment
① The pain is very mild at the moment
② The pain comes and goes and is moderate
③ The pain is fairly severe at the moment
④ The pain is very severe at the moment
⑤ The pain is the worst imaginable at the moment

Sleeping
⓪ I have no trouble sleeping
① My sleep is slightly disturbed (less than 1 hour sleepless)
② My sleep is mildly disturbed (1-2 hours sleepless)
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading
⓪ I can read as much as I want with no neck pain
① I can read as much as I want with slight neck pain
② I can read as much as I want with moderate neck pain
③ I cannot read as much as I want because of moderate neck pain
④ I can hardly read at all because of severe neck pain
⑤I cannot read at all because of neck pain

Concentration
⓪ I can concentrate fully when I want with no difficulty
① I can concentrate fully when I want with slight difficulty
② I have a fair degree of difficulty concentrating when I want
③ I have a lot of difficulty concentrating when I want
④ I have a great deal of difficulty concentrating when I want
⑤ I cannot concentrate at all

Work
⓪ I can do as much work as I want
① I can only do my usual work but no more
② I can only do most of my usual work but no more
③ I cannot do my usual work
④ I can hardly do any work at all
⑤ I cannot do any work at all

Personal Care
⓪ I can look after myself normally without causing extra pain
① I can look after myself normally but it causes extra pain
② it is painful to look after myself and I am slow and careful
③ I need some help but I manage most of my personal care
④ I need help every day in most aspects of self care
⑤ I do not get dressed, I was with difficulty and stay in bed.

Lifting
⓪ I can lift heavy weights without extra pain
① I can lift heavy weights but it causes extra pain
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving
⓪ I can drive my car without any neck pain
① I can drive my car as long as I want with slight neck pain
② I can drive my car as long as I want with moderate neck pain
③ I cannot drive my car as long as I want because of moderate neck pain
④ I can hardly drive at all because of severe neck pain
⑤ I cannot drive my car at all because of neck pain

Recreation
⓪ I am able to engage in all my recreation activities without neck pain
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain
⑤ I cannot do any recreation activities at all

Headaches
⓪ I have no headaches at all
① I have slight headaches, which come infrequently
②I have moderate headaches, which come infrequently
③ I have moderate headaches, which come frequently
④ I have severe headaches, which come frequently
⑤ I have headaches almost all the time

Index Score = [Sum of all statements selected/(# of sections with a statement selected x 5)] x 100

SCORE___________________
PREVIOUS SCORE___________________ DATE________________

Patient Name____Date____

Rev 7-26-07

COMPLETE ONLY IF WE ARE TREATING THIS PART OF YOUR BODY

GEORGETOWN THERAPY

Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb. The problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Getting into or out of the bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your shoes or socks	0	1	2	3	4
6	Squatting	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8	Performing light activities around your home	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into or out of a car	0	1	2	3	4
11	Walking 2 blocks	0	1	2	3	4
12	Walking a mile	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14	Standing for 1 hour	0	1	2	3	4
15	Sitting for 1 hour	0	1	2	3	4
16	Running on even ground	0	1	2	3	4
17	Running on uneven ground	0	1	2	3	4
18	Making sharp turns while running fast	0	1	2	3	4
19	Hopping	0	1	2	3	4
20	Rolling over in bed	0	1	2	3	4
	Column Totals					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE____________**/80**

PREVIOUS SCORE____________**/80 Date**________________

Patient Name______________________________________**Date**________

GEORGETOWN THERAPY

BACK INDEX

Patient Name____**Date**___________________________

This questionnaire will give your therapist information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark only the one that most closely describes your problem.

Pain Intensity

- ☐ The pain comes and goes and is very mild
- ☐ The pain is mild and does not vary much
- ☐ The pain comes and goes and is moderate
- ☐ The pain is moderate and does not vary much
- ☐ The pain comes and goes and is very severe
- ☐ The pain is very severe and does not vary much

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing, even though it causes some pain
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it
- ☐ Washing and dressing increases the pain and I find it necessary to change my of doing it
- ☐ Because of pain I am unable to do some washing and dressing without help
- ☐ Because of the pain I am unable to do any washing and dressing without help

Sleeping

- ☐ I get no pain in bed
- ☐ I get pain in bed but it does not prevent from sleeping well
- ☐ Because of pain my normal sleep is reduced by less than 25%
- ☐ Because of pain my normal sleep is reduced by less than 50%
- ☐ Because of pain my normal sleep is reduced by less than 75%
- ☐ Pain prevents me from sleeping at all

Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift weights but it causes extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights.

Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ I avoid sitting because it increases pain immediately

Traveling

- ☐ I get no pain while traveling
- ☐ I get some pain while traveling but none of my usual forms of travel make it worse
- ☐ I get extra pain while traveling but it does not cause me to seek alternate forms of travel
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel
- ☐ Pain restricts all forms of travel except that done while lying down
- ☐ Pain restricts all forms of travel

Standing

- ☐ I can stand as long as I want without pain
- ☐ I have some pain while standing but it does not increase with time
- ☐ I cannot stand for longer than 1 hour without increasing pain
- ☐ I cannot stand for longer than ½ hour without increasing pain
- ☐ I cannot stand for longer than 10 minutes without increasing pain
- ☐ I avoid standing because it increases pain immediately

Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc)
- ☐ Pain has restricted my social life and I do not go out very often
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of the pain

Walking

- ☐ I have no pain while walking
- ☐ I have some pain while walking but it doesn't increase with distance
- ☐ I cannot walk more than 1 mile without increasing pain
- ☐ I cannot walk more than ½ mile without increasing pain
- ☐ I cannot walk more than ¼ mile without increasing pain
- ☐ I cannot walk at all without increasing pain

Changing degree of pain

- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is definitely getting better
- ☐ My pain seems to be getting better but improvement is slow
- ☐ My pain is neither getting better or worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

……………………………………………………………**FOR OFFICE USE ONLY**……………………………………………………………

Index Score = [Sum of all statements selected/ (# of sections with a statement selected x 5)] x 100

Score____________________

Previous Score____________________ **Date**___________

Patient Name________________________________**Date**____

COMPLETE ONLY IF WE ARE TREATING THIS PART OF YOUR BODY

GEORGETOWN THERAPY

QUICKDASH WORK MODULE/SPORTS MODULE

(ARM, SHOULDER, HAND AFFECTING YOUR WORK OR SPORTS LIFE)

PATIENT NAME______________________________________DATE__________________________

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 DFFICULTY	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	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 DFFICULTY	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 practicing or playing your instrument or sport?	1	2	3	4	5

QuickDASH Optional Modules Score = (sum of n responses) – 1 x 25 where n is equal to number of completed responses.
4

Current Score _____________________ **Prior Score**_____________ **Date**_______________________

Optional Module score may not be calculated if there is greater than 1 missing item