**Therapy Treatment Agreement – Flaming Physical Therapy**

11 Elsinore Avenue, Bath, Maine 207-442-9810 68 Chapman Street, Damariscotta, Maine 207-563-7990

This document is a treatment agreement in which the patient, or the responsible party for the patient, and Flaming Physical Therapy are identified below. The patient, or responsible party, consents to evaluations and treatments upon the provisions hereof, and patient, responsible party and Flaming Physical Therapy hereby agree with each other as follows:

**PATIENT NAME**; LAST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If Different from above)

**PHONE**: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**E-MAIL**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male: \_\_\_\_\_\_ Female: \_\_\_\_\_\_

Marital Status: Married: \_\_\_\_\_ Single: \_\_\_\_\_\_ Other: \_\_\_\_\_\_

**WORK STATUS**: Employed: \_\_\_\_ Unemployed: \_\_\_\_ F/T Student: \_\_\_\_ Retired: \_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP TO SUBSCRIBER**: Self: \_\_\_\_ Spouse: \_\_\_\_ Child: \_\_\_\_ Other: \_\_\_\_

 IF Someone other than the patient is the subscriber; Please fill out below:

 Name of Subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Birth Date: \_\_\_ / \_\_\_ /\_\_\_

 Address (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Patient Condition related to (or results of) any of the Following?

 Employment? YES \_\_\_\_ NO \_\_\_\_ If YES, is this Workers Compensation? \_\_\_\_\_\_\_

 Auto Accident YES \_\_\_\_ NO \_\_\_\_ IF YES, who’s Insurance is Responsible? \_\_\_\_\_\_

 Other Accident YES \_\_\_\_ NO \_\_\_\_ If YES, Which Insurance is Responsible? \_\_\_\_\_\_

Use Space Below to Explain:

**DIAGNOSIS** of Injury / Illness / Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Current Injury / Surgery / other: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

Date P.T. Ordered: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

Patient’s Next Physician Follow up visit \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**PRIMARY PHYSICIAN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ordering Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Payment Amount for Physical Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CO-PAYMENTS ARE COLLECTED AT EACH VISIT. YOU WILL BE BILLED FOR ANY COINSURANCE BALANCE AS INDICATED BY YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO KNOW YOUR COINSURANCE*.

**AUTHORIZATION for RELEASE OF INFORMATION**: The institution rendering services is hereby authorized to furnish and release, in accordance with facility policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third party, agents or agencies from the medical records compiled during treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

**TREATMENT CONSENT**: I, the undersigned, so hereby agree and give my consent and authorization for Glenn Flaming Physical Therapy to provide examination, treatments and services to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments and services.

**ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS**: I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility’s regular charges for this period of treatment. I understand I am responsible to the facility for the charges NOT covered NOR paid by my Insurance, or through Worker’s Compensation.

**CANCELLATION / NO SHOW POLICY**: Your well being is our highest concern. For you to benefit from your Physical Therapy treatment, we encourage you to keep each scheduled appointment. We realize that this is not always possible. Therefore, if you must cancel, we ask that you call the office at least 24 hours prior to the scheduled appointment time. Failure to cancel within the allotted time frame mentioned **will result in a $50.00 charge**, or the amount of your co-pay, **WHICH EVER IS THE GREATER AMOUNT**. This charge will be collected at the next scheduled appointment or will be billed to you upon Discharge. As always, we are glad to answer any questions and work with you if you have special circumstances. **Ongoing failure to keep your appointments may result in decision to terminate your therapy with us.**

PATIENT (or GUARDIAN) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Self-Evaluation Form - Flaming Physical Therapy**

 11 Elsinore Avenue, Bath 207-442-9810 68 Chapman Street, Damariscotta 207-563-7990

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Date of Original Injury, symptoms or Pain: \_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENT CONDITION / PAIN / SYMPTOMS:

1. Please Shade or make an “X” in area (or areas) where you are experiencing pain /symptoms.
2. If the symptoms travel/radiate, use an “arrow” to follow the path of pain
3. Feel free to use more than one symbol

 

1. Current Injury/Symptom Descriptors: Circle any/all words that apply, add others

1. When and what initially caused you to seek Physical Therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List symptom(s) that you “INITIALLY” experienced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	1. Severity Initially: 0 1 2 3 4 5 6 7 8 9 10
2. List Symptom(s) that you “CURRENTLY” experience \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	1. Severity Currently: 0 1 2 3 4 5 6 7 8 9 10
3. Since Initiation, how has the pain changed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Self-Evaluation Form – Flaming Physical Therapy (Continued)

1. Since onset have your symptoms become:
	1. BETTER B. WORSE C. No CHANGE
2. How often do you experience the Symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What makes your symptoms Worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sitting Standing Walking Bending Lifting Other

1. What eases your Symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sitting Standing Walking Bending Lifting Other

1. How much does your pain interfere with your activities?
	1. None (0%) Rarely (1-19%) Often (20-39%)
	2. Moderate (40-59%) Almost always (60-79%) Always (80-100)
2. Are you taking any Medications related to the reason you’re in PT? YES NO
	1. If yes, What and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST HISTORY OF SYMPTOMS

1. Have you ever had these kinds of symptoms before? YES NO

If YES, When was the previous episode? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How often have they reoccurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has the frequency of severity of these symptoms increased since that former episode?
	1. FREQUENCY? YES NO B. Severity: YES NO

PAST MEDICAL HISTORY

Accidents or injuries? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer? YES NO COPD YES NO

Arthritis YES NO Neurologic Disorders YES NO

Pregnancy? YES NO Parkinson’s YES NO

Immunosuppression? YES NO Pacemaker YES NO

Have you had other related P.T or Body work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing, I certify that all information in this form is true and correct to the best of my knowledge.

Patient (or Guardian) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Patient /Guardian Name (PRINTED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Notice of Privacy Practices – Flaming Physical Therapy**

## 11 Elsinore Avenue, Bath, Maine 207-442-9810

68 Chapman Street, Damariscotta, Maine 207-563-7990

Flaming Physical Therapy (FPT) pledges to maintain the privacy and confidentiality of our patients at all times. The full written privacy policy is available upon request. Any complaints regarding privacy issues should be addressed with the management at Flaming Physical Therapy.

All employees at FPT pledge to keep your health information confidential; however, your conversations may, at times, be overheard by other parties. You may meet with your Therapist of other staff members in a private room if this is a concern.

# HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

# In accordance with government guidelines, we are herein asking for your consent in sharing necessary information about your care at FPT with other parties including but not limited to your Physician, Health Insurance Carrier, Lawyer, or Case Manager. Necessary information may include but is not limited to the following areas; For Treatment, For Payment of services, For Health Care Operations, Judicial and Administrative Proceedings, to avoid a serious threat to health or safety, Health Oversight Activities, Law Enforcement and Worker’s Compensation.

# YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information that we may obtain from you. You have the Right to inspect and copy any protected health information that may be used to make decisions about your care. You have the right to amend or supplement health information, if you feel that it is incorrect or incomplete. You have the right to request an “accounting of disclosures”. You have the right to request restrictions or limitations on information we use or disclose about you. You have the right to a paper copy of this notice.

### FLAMING PHYSICAL THERAPY IS ASKING FOR YOUR SPECIFIC DIRECTIVES IN THE FOLLOWING AREAS

**Please initial ONE of the following options:**

 FPT has my consent to share necessary information regarding my Physical Therapy care as needed in accordance with the HIPAA Privacy Act.

 FPT has my consent to share health information with ONLY THE FOLLOWING PARTIES:

In order to comply with federal regulations, we ask for your consent regarding TELEPHONE MESSAGES.

 I authorize a telephone message may be left with any person or machine answering a phone call intended for me.

 Telephone messages may be left ONLY WITH THE FOLLOWING: I have read and understand the FPT privacy policy and consent to the sharing of necessary information about my care between appropriate parties in accordance with the HIPAA Privacy Act unless directed otherwise

PATIENT (or GUARDIAN) Signature: DATE: \_\_\_/ \_\_\_/ \_\_\_\_\_\_

PATIENT NAME AND BIRTH DATE (PRINTED): \_ DOB: / / PARENT OR GUARDIAN NAME (PRINTED):

**NECK DISABILITY INDEX**

**YOUR NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_**

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and MARK IN EACH SCTION ONLY ONE BOX THAT APPLIES TO YOU. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

**Section 1: Pain Intensity**

* 0. I have no pain at this moment
* 1. The pain is very mild at this moment
* 2. The pain is moderate at this moment
* 3. The pain is fairly severe at this moment
* 4. The pain is very severe at this moment
* 5. The pain is the worst imaginable at this moment

**Section 2: Personal Care (Washing, Dressing, etc.)**

* 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 can 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 wash with difficulty and stay in bed

**Section 3: Lifting**

* 0. I can lift heavy weights without extra pain
* 1. I can lift heavy weights but it gives extra pain
* 2. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
* 3. Pain prevents me from lifting heavy weights 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

**Section 4: Reading**

* 0. I can read as much as I want to with no pain in my neck
* 1. I can read as much as I want to with slight pain in my neck
* 2. I can read as much as I want with moderate pain in my neck
* 3. I can’t read as much as I want because of moderate pain in my neck
* 4. I can hardly read at all because of severe pain in my neck
* 5. I cannot read at all

**Section 5: Headaches**

* 1. I have no headaches at all
* 1. I have slight headaches, which come infrequently
* 2. I 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

**Section 6: Concentration**

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

**Section 7: Work**

* 0. I can do as much work as I want to
* 1. I can only do my usual work, but no more
* 2. I can 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 can’t do any work at all

**Section 8: Driving**

* 0. I can drive my car without any neck pain
* 1. I can drive my car as long as I want with slight pain in my neck
* 2. I can drive my car as long as I want with moderate pain in my neck
* 3. I can’t drive my car as long as I want because of moderate pain in my neck
* 4. I can hardly drive at all because of severe pain in my neck
* 5. I can’t drive my car at all

**Section 9: Sleeping**

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

**Section 10: Recreation**

* 0. I am able to engage in all my recreation activities with no neck pain at all
* 1. I am able to engage in all my recreation activities, with some pain in my neck
* 2. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
* 3. I am able to engage in a few of my usual recreation activities because of pain in my neck
* 4. I can hardly do any recreation activities because of pain in my neck
* 5. I can’t do any recreation activities at all

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_\_\_

SCORE: \_\_\_\_/ 50 TRANSFORM TO PERCENTAGE SCORE X 100 = \_\_\_\_%POINTS

QUICK DASH

Patient Name: Date of Birth: Today’s 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 | SEVERELY DIFFICULTY | UNABLE TO DO |
| 1. Open a tight or new jar. | 1 | 2 | 3 | 4 | 5 |
| 2. Do heavy household chores (i.e., 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 (i.e., 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 normalsocial activities with family, friends, neighbors or groups? | 1 | 2 | 3 | 4 | 5 |
|  | NOT LIMITED AT ALL | SLIGHTLY LIMITED | MODERATELY LIMITED | VERY LIMITED | UNABLE TO DO |
| 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 ITPREVENTS SLEEP |
| 11. During the past week, how much difficulty have you had | 1 | 2 | 3 | 4 | 5 |
| sleeping because of the pain in your arm, shoulder or hand(circle one)? |

Since the beginning of therapy my condition has improved:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

During the past 24 hours, my maximum pain rating was:

0 1 2 3 4 5 6 7 8 9 10

This section to be completed by your Physical Therapist/Provider

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

QUICK DASH DISABILITY SYMPTOM SCORE

(sum of n response) – 1 X 25

n