Name: _____ Date:_____ Doctor:_____

Example: Weight loss •

Review of Systems

Weight loss	O	Eye Injury	O	Other Psychiatric Disorders	O
Excessive Fatigue	O	Chest pain	O	Asthma	O
Hearing loss	O	High Blood Pressure	O	Chronic Cough	O
Ear infections	O	Irregular Pulse	O	Shortness of breath	O
Ringing in ears	O	High Cholesterol	O	Chronic Bronchitis	O
Diabetes	O	Seizures	O	Arthritis	O
Thyroid Disorder	O	Weakness	O	Back Pain	O
Increased Appetite	O	Stroke	O	Joint Swelling	O
Excessive thirst	O	Blurred Vision	O	Broken Bones	O
Bleeding Disorders	O	Nausea	O	Blood in urine	O
HIV Positive	O	Vomiting	O	Painful Urination	O
Hepatitis Type A	O	Loose stools	O	Allergy to food	O
Hepatitis Type B	O	Abdominal pain	O	Immune disorders	O
Hepatitis Type C	O	Anxiety	O		
Eye Infections	O	Depression	O		

Healthy, no known medical problems O

Other than what has been chosen from above, no other known medical problems O

Social History

Work Status O Full-time O Part-time O Retired O Unemployed O Disabled

Marital status O Single O Married O Divorced O Widowed

Tobacco use O Yes O No : Packs/day O 1 O 2 or more O Cig/pipe O Smokeless Tobacco

Alcohol use O Yes O No O Rarely

Family History

High Blood Pressure	O	Rheumatoid Arthritis	O	Gout	O
Diabetes	O	Thyroid Condition	O	Stroke	O
Congestive Heart Failure	O	Cancer	O	Osteoarthritis	O

No Known Medical Problems O

PATIENT INFORMATION:

Date: _____ **Doctor**_____

Name:_____ **Birth Date:** ____/____/____

Last Name First Name Middle Initial

Address:_____City_____State_____Zip Code_____

Home Phone# (____)_____**Cell Phone#** (____)_____

Employer:_____ **Job Title:** _____

Work Phone# (____)_____**Were you injured at work?**_____ **YES** _____**NO**

Preferred contact phone #: HOME PHONE, CELL PHONE, WORK, PHONE (please circle one)

SSN#_____-_____-_____ Alternate/Emergency Contact: _____

Relationship to patient:_____ **Phone:#** _____

PLEASE CIRCLE WHAT APPLIES TO YOU:

Marital Status: Single/Married/Widowed/Divorced **Sex**: Male/Female

RACE: White/American, Indian/Alaska Native, Black/African American, Asian, Hispanic, Native Hawaiian, Other

ETHNICITY: Hispanic, Non-Hispanic, Refused to Report

PREFERRED LANGUAGE: English, Spanish, Indian, Russian, Other_____

Please complete responsible party information -- unless the patient is covered under Work COMP:

_____Check here if responsible party is the same as above

Name:_____ SSN#_____-_____-_____

Last Name First Name Middle Initial

Date of birth: ____/____/____ Relationship to patient: _____Phone#(____)_____

Address:_____City_____State_____ZipCode_____

Employer:_____ Phone#(____)_____

I consent to the use or disclosure of my protected health information by Hand Center of Evansville for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I hereby guarantee payment of all charges and authorize and direct payment from any insurance company, to include, but not limited to, Medicare, Medicare supplement, Medicaid, employer, attorney or their representative to be made directly to Hand Center of Evansville in accordance with federal, state, local and carrier billing regulations and guidelines. In the event my account becomes more than 30 days past due and is referred to a collection agency, I agree to pay collection agency fees, reasonable attorney and/or court costs. Medical forms are to be completed by office staff and not by the physician. Charges may apply. Payment is expected when services are rendered unless other arrangements have been made prior to the appointment. **I UNDERSTAND MY CO-PAY IS DUE ON EVERY DATE OF SERVICE. IF UNABLE TO MAKE THE REQUIRED CO-PAY, I MAY BE RESCHEDULED.**

SIGNATURE OF RESPONSIBLE PARTY_____**DATE**_____

If the above signature does not belong to the patient, please list your relationship._____

Hand Center of Evansville Patient History Form Date: _____

Name: _____ Primary Care Physician_____
(First & Last Name) (First & Last Name)

Were you injured on the job? _____YES _____NO **If YES,** has the injury/symptoms been reported to your employer? _____YES _____NO

Were you seen at any ER for this problem? YES NO If so, where? _____ When? _____

Have you had X-rays for this problem? YES NO If so, where? _____ When? _____

Is there a possibility of pregnancy or are you currently pregnant? YES NO

Age_____ Weight_____ Height_____ **Are you**: _____ Right handed _____Left handed

Body Part of Problem/injury: _____

Duration: When did the symptoms start, or date of injury: _____

How did your symptoms or injury begin/occur? _____

Please circle all that applies:

Associated Symptoms: i.e.: Numbness, Tingling, Weakness, Swelling, Pain, Radiation of pain, Deformity, Popping, Catching, Locking, Drainage, List other_____

Previous evaluation and treatment: Oral Anti-Inflammatory, Splint/bracing, Physical/Occupational therapy, Injection, Surgery, Other: _____

Quality of pain; is your pain: Sharp, Stabbing, Toothache-Type, Throbbing, Dull, Burning. List other_____

Severity: Rate the intensity of pain (0 = no pain, 10 = the worst pain you can imagine): 0 1 2 3 4 5 6 7 8 9 10

Timing when your symptoms occur: Day, Night, While working, Daily Activity, Constant

Please list current medications; with dosages (Use the back of this sheet if necessary). **If NONE please check ____**

_____

_____

_____

ALLERGIES to Medications with Allergic reaction/symptoms: **If NONE please check here _____**

_____ _____ _____

Past significant illness/Injuries/Hospitalizations (Do not include surgical procedures): **If NONE please check here _____**

_____ _____ _____ _____

Previous Surgeries with approximate date: **If NONE please check here___**

Tonsillectomy____ Hysterectomy_____ Prostate_____ Knee_____ Hip_____ Spine_____ Ear/Nose/Throat_____

Heart Surgery____ Stent Placement_____ Appendectomy_____ Other Surgeries not listed: _____

***** If you need to list additional information please use the back of this sheet

HAND CENTER of Evansville
Ross E. Marburger, MD & John P. Morgan, MD
1150 Lincoln Avenue Evansville, IN 47714
Phone: (812) 402-HAND (4263) Fax: (812) 437-HAND

APPOINTMENT OF PERSONAL REPRESENTATIVE TO RECEIVE PROTECTED HEALTH INFORMATION

You may rely upon your spouse, relatives or friends from time-to-time to visit your physician, acquire prescriptions, receive test results, or help you understand your treatment options and alternatives. However, the Federal Health Insurance Portability and Accountability Act (HIPAA) and Indiana law do not allow us to disclose any of this information to these individuals unless you appoint them as a "personal representative".

If you wish to appoint an individual(s) as your personal representative, please complete this form.
*****A personal rep for example would be able to call regarding an appointment, pick up a prescription, etc.**
***You may choose what your personal rep has access to.**

I HEREBY AUTHORIZE HAND CENTER OF EVANSVILLE TO RELEASE THE FOLLOWING PROTECTED HEALTH INFORMATION TO THE INDIVIDUAL(S) DESIGNATED BELOW:

Print name of personal representative released:	***Relationship to patient***	***Check information to be***
1._____	_____	☐ Appointment ☐ Billing/Insurance ☐ Emergency Contact ☐ Any/All information
Phone: _____	_____	
2._____	_____	☐ Appointment ☐ Billing/Insurance ☐ Emergency Contact ☐ Any/All information
Phone: _____	_____	

I MAY REVOKE THIS APPOINTMENT AT ANY TIME. MY REVOCATION WILL NOT AFFECT ANY ACTIONS THAT HAVE ALREADY BEEN TAKEN IN RELIANCE ON MY ORIGINAL APPOINTMENT.
This appointment is valid for 60 days unless specified below. Please check one option below.

☐Valid 60 days from the date this form is signed

☐Valid for 60 days with automatic renewal until revoked in writing. I may revoke in writing at any time.

I acknowledge that I have received the Notice of Privacy Practices for Protected Health Information of Hand Center of Evansville.

X_____ _____ _____

Print Name

Signature IS REQUIRED (with or without personal rep appointed) Date

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 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 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 IT PREVENTS SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand (circle one)?	1	2	3	4	5

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

$$\frac{(\text{sum of n response})}{n} - 1 \times 25$$