OCCUPATIONAL HAND THERAPY

Patient Registration/Information

Patient Name:_____ **Dx:**_____ **Physician:**

❑ Dr. Gargasz
❑ Dr. Miller

Date of Injury:_____
How Did Your Injury Occurred?:

_____

_____

Surgery Date:_____
Current Work Status: ❑Light Duty ❑Medium Duty ❑Full Duty ❑Not Working ❑Retired
❑ One Handed Duty ❑Other (specify):_____
Job Titled:_____

Medical History(Please Check All That Apply) : ❑No health or medical Issues

❑ Anxiety	❑Depression	❑Kidney Problems
❑Asthma	❑Diabetes	❑Lung Problems
❑Bipolar	❑Heart Problems	❑Peripheral Vascular Disease
❑Cancer	❑High Blood Pressure	❑Rheumatoid Arthritis
❑COPD	❑Osteoarthritis	❑Thyroid Problems

Prior Hand Injury: ❑Yes ❑No ❑If yes, type of injury_____ ❑right ❑left ❑both

Past Surgical History (Please Check All That Apply): ❑No Surgeries

☐Adenoidectomy	☐Hysterectomy	☐Breast Biopsy	☐ Elbow
☐Angioplasty	☐Neck Surgery	☐Right	☐Right
☐Appendectomy	☐ Oral Surgery	☐Left	☐Left
☐Back Surgery	☐Prostate Surgery	☐Both	☐Both
☐Cosmetic Surgery	☐Reconstructive Surgery	☐ Carpal Tunnel	☐ Knee
☐C-Section / Cesarean	☐Stent Placement	☐Right	☐Right
☐Endoscopy	☐Stomach Surgery	☐Left	☐Left
☐Eye Surgery	☐Thyroid Surgery	☐Both	☐Both
☐Gall Bladder Removal	☐Tonsillectomy	☐ Cubital Tunnel	☐ Shoulder
☐Gastric Bypass	☐Trigger Finger Release	☐Right	☐Right
☐Heart Surgery	☐Tubal Ligation	☐Left	☐Left
☐Hemorrhoid Surgery	☐Vasectomy	☐Both	☐Both
☐Hernia Surgery	☐Wound Care		

Other: _____

Family Status: ❑Single ❑Married ❑Partnered ❑Divorced ❑Legally Separated ❑Widowed

QUICK DASH

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 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, 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, 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

Notice of Privacy Practices

I, _____have had the opportunity to read and review the Notice of Privacy Practices for Advanced Hand and Plastic Surgery Center. All of my questions regarding HIPAA and the use of my protected health information have been answered to my satisfaction.

Patient Signature:_____

If patient is a minor, Parent or Guardian Signature:_____

Date:_____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION PERTAINING TO MY HEALTH TO THE FOLLOWING:

List Person or Persons:

1._____

2._____

3._____

4._____

Patient Signature:_____