

ELBOW ASSESSMENT FORM
AMERICAN SHOULDER AND ELBOW SURGEONS

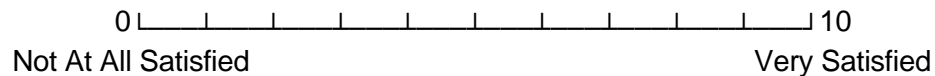
Name:		Date
Age:	Hand dominance: R L Ambi	Sex: M F
Diagnosis:		Initial Assess? Y N
Procedure/Date:		Follow-up: M Y Involved Elbow: R L

Circle the number in the box that indicates your ability to do the following activities:
0 = **Unable** to do; 1 = **Very** difficult to do; 2 = **Somewhat** difficult; 3 = **Not** difficult

ACTIVITY	RIGHT ARM	LEFT ARM
1. Do up top button on shirt	0 1 2 3	0 1 2 3
2. Tie shoes	0 1 2 3	0 1 2 3
3. Eat with utensil	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Carry a heavy object	0 1 2 3	0 1 2 3
7. Raise from chair pushing with arm	0 1 2 3	0 1 2 3
8. Do heavy household chores	0 1 2 3	0 1 2 3
9. Turn a key	0 1 2 3	0 1 2 3
10. Throw a ball overhand	0 1 2 3	0 1 2 3
11. Do usual work - Describe:	0 1 2 3	0 1 2 3
12. Do usual sport - Describe:	0 1 2 3	0 1 2 3

PATIENT SELF-EVALUATION: SATISFACTION

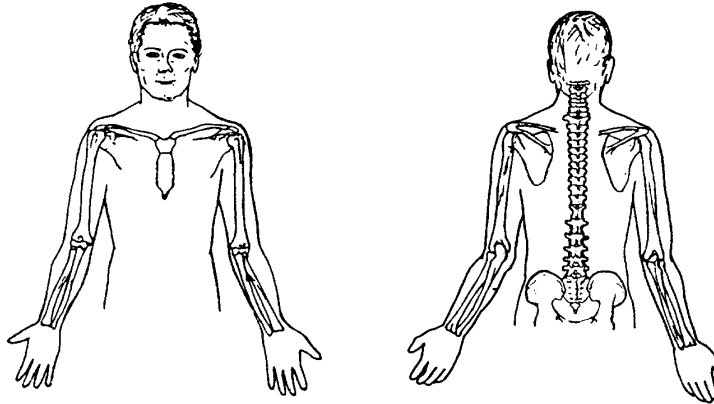
Are You Satisfied With Your Elbow Surgery?
(Circle number if applicable)



PATIENT SELF-EVALUATION

Are you having pain in your Elbow? (circle correct answer)	Yes	No
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Mark where your pain is on this diagram:



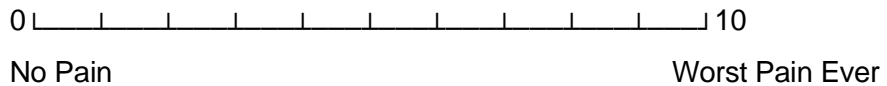
Do you take pain medication (aspirin, Advil, Tylenol etc.)?	Yes	No
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Do you take narcotic pain medication (codeine or stronger)?	Yes	No
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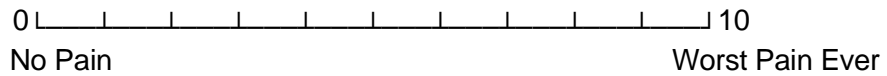
How many pills do you take each day (average)?	# ___ pills
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Rate Your Elbow Pain: (Circle Number)

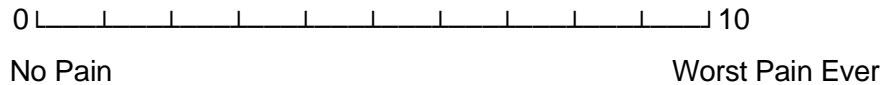
When it is at its worst



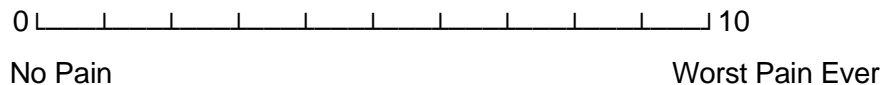
At Rest



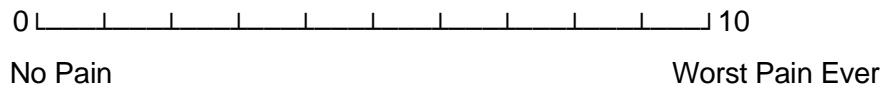
Lifting a heavy object



When doing a task with repeated elbow movements



At night



PATIENT DEMOGRAPHIC INSURANCE FORM

Name: _____ Today's Date: _____

Address: _____ Apt # _____ City / Town _____

State _____ Zip code _____ * E-MAIL _____

Telephone: _____ Work #: _____ Cell #: _____

Date of Birth: _____ Sex: Male ___ Female ___ Social Security # _____ - _____ - _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___

Employer: _____

Primary Insurance Carrier: _____

Identification Number: _____

Name of Insured/Relation: _____ SS# _____ DOB _____

Secondary Insurance Carrier: _____ Identification Number: _____

Name of Insured/Relation: _____ SS# _____ DOB _____

Insured Employer: _____ Work Number: _____

Referral Source: MD: ___ Relative/Friend: ___ Yellow Pages: ___ Other: _____

Referring Physician _____ Office # _____

Physician Address: _____

Pharmacy: _____ Pharmacy Telephone #: _____

Pharmacy Address: _____

In care of emergency notify: _____ Telephone: _____

Relationship: _____

PLEASE DATE AND SIGN BELOW

The provider may release to governmental agencies, insurance carriers or their designated agents or the legal or financial departments representing me or the provider, all information needed to substantiate payment for my medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date: _____ Signed _____

I hereby assign, transfer, and set over to the above mentioned physician monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs of the treatment rendered to myself or my dependent, during this hospitalization.

Date: _____ Signed _____