



NEW PATIENT INFORMATION SHEET

HOW DID YOU HEAR ABOUT US? [ ] PHYSICIAN [ ] WEBSITE [ ] FACEBOOK
[ ] SEMINAR [ ] NEWSPAPER AD [ ] FRIEND [ ] RETURNING PATIENT [ ] OTHER

Name (First) (Middle) (Last) (Suffix)

Mailing Address

(City) (State) (ZIP)

Phone: Home Cell Work

Primary Phone Email Address

Date of Birth Age Marital Status: [ ] Married [ ] Divorced [ ] Single [ ] Other [ ] Unknown

[ ] Widowed [ ] Separated Gender: [ ] Male [ ] Female Social Security #

Driver License #

Employment Status: [ ] Full Time [ ] Part Time [ ] Not Employed [ ] Self-Employed [ ] Retired [ ] Active Military
[ ] Unknown [ ] Full Time Student

In case of emergency, please notify Phone

Attorney involvement? [ ] Yes [ ] No Attorney name Phone

Name of Employer, Parent or Guarantor

Street Address of Employer or Parent

City, State and ZIP of Employer or Parent

Name of Spouse Spouse Date of Birth

Spouse's Employer Phone

Have you received any therapy this year? [ ] Yes [ ] No

Have you been seen for nursing or physical therapy services in your home by a Home Health Agency prior to
requesting services through our organization? [ ] Yes [ ] No If yes, name of home health agency

Primary Care Provider/Family Doctor Phone

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The two documents listed below are available for review at the Rehab Therapy Works front office.

- 1. Authorization for Treatment, Assignment of Benefits, Payment Responsibility and Disclosure of ALF Resident
Information.
2. Acknowledgement of Receipt of Privacy Notice in combination with Voluntary Consent.

The listed individuals may have access to my PHI (Protected Health Information):

Patient/Representative Signature Date

Witness Date

Guardian Signature if patient is a minor Date

Relationship to Patient



\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Facility

**SCREENING FOR PREVIOUS PT/OT/ST SERVICES UNDER  
MEDICARE PART B CAPS**

**Effective January 1, 2019, therapy providers are required to assure that Medicare is not billed more than \$2,040 for physical and speech therapy services combined, and \$2,040 for occupational therapy services. Each provider is required to track the entire therapy episode regardless of setting.**

1. Have you previously received Part B therapy services in a skilled nursing facility?  
 Yes  No If yes, by whom and how much? \_\_\_\_\_  
\_\_\_\_\_
2. Have you previously received Part B therapy services in a physician's office?  Yes  No  
If yes, by whom and how much? \_\_\_\_\_  
\_\_\_\_\_
3. Have you previously received Part B therapy services in an outpatient clinic?  Yes  No  
If yes, by whom and how much? \_\_\_\_\_  
\_\_\_\_\_
4. Have you previously received Part B therapy services in your home?  Yes  No  
If yes, by whom and how much? \_\_\_\_\_  
\_\_\_\_\_

Signing below indicates that the answers above are true and correct, and that the information is complete to the best of the signor's knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient \_\_\_\_\_

Medicare # \_\_\_\_\_ Admit/Eval Date \_\_\_\_\_

Facility \_\_\_\_\_ Provider # \_\_\_\_\_

1. Is the patient covered by Veterans Administration or Black Lung?  Yes  No
2. Was illness due to an injury?  Yes  No If yes,
  - a. Date of accident \_\_\_\_\_
  - b. What type of accident cause your illness/injury? \_\_\_\_\_
  - c. Is the patient filing or intending to file a liability suite? \_\_\_\_\_  
If yes, please give name and address of attorney \_\_\_\_\_
3. Is the patient employed (Medicare disabled beneficiaries under the age of 65 or Medicare over the age of 65) and covered by a group health plan?  Yes  No
  - a. Date of retirement \_\_\_\_\_
  - b. Is the patient married? \_\_\_\_\_
  - c. Is the spouse currently employed? \_\_\_\_\_
  - d. Does the spouse have group coverage? \_\_\_\_\_
  - e. Does the patient have coverage through a spouse, parent or guardian's employer group health plan? \_\_\_\_\_
4. Is the patient entitled to benefits solely on the basis of end stage renal disease?  Yes  No Has the patient been undergoing kidney dialysis for more than 12 months?  Yes  No

*If you answered yes to any of the above questions, you will need to fill out the information requested below.*

Insurance company \_\_\_\_\_

Address \_\_\_\_\_

Policy/certificate number \_\_\_\_\_

Group name \_\_\_\_\_

Group number \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Signature of person completing this form \_\_\_\_\_ Date \_\_\_\_\_  
(If other than the patient)

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please check any of the following conditions you have, or have had -OR-  No medical history to report

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Kidney disease                 | <input type="checkbox"/> Thyroid disease  | the following? (Check all that apply) |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Diabetes mellitus              | <input type="checkbox"/> Tuberculosis   |                                       |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Clotting disorder (blood clot) | <input type="checkbox"/> Ulcers   |                                       |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> High blood pressure            | <input type="checkbox"/> Cataracts  |                                       |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Acid reflux                    | <input type="checkbox"/> Other _____  |                                       |
| <input type="checkbox"/> Blood disorders          | <input type="checkbox"/> Glaucoma                       | _____   |                                       |
| <input type="checkbox"/> Blood transfusion        | <input type="checkbox"/> Gout                           | _____   |                                       |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Heart attack                   |   |                                       |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> High cholesterol               |   |                                       |
| <input type="checkbox"/> Nerve/muscle disease     | <input type="checkbox"/> Osteoporosis                   |   |                                       |
| <input type="checkbox"/> Lung disease             | <input type="checkbox"/> Seizures                       | <b>For men only:</b> Have you been diagnosed with prostrate disease? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                       |
| <input type="checkbox"/> Meningitis               | <input type="checkbox"/> Sickle cell anemia             | <b>For women only:</b> Have you ever been diagnosed with any of _____   |                                       |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Stroke                         | _____   |                                       |
| <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Substance abuse                | _____   |                                       |

**PAST SURGICAL HISTORY**

Please check any surgery you have had -OR-  Never had surgery

- |   |  |
|---|--|
| <input type="checkbox"/> Breast surgery ..... Year _____              | <input type="checkbox"/> Tubes tied ..... Year _____             |
| <input type="checkbox"/> Open heart or bypass surgery..... Year _____ | <input type="checkbox"/> Hysterectomy..... Year _____            |
| <input type="checkbox"/> Gall bladder ..... Year _____                | <input type="checkbox"/> Heart valve replacement..... Year _____ |
| <input type="checkbox"/> Colon surgery..... Year _____                | <input type="checkbox"/> Orthopaedic surgery..... Year _____     |
| <input type="checkbox"/> Fracture surgery ..... Year _____            | <input type="checkbox"/> Orthopaedic surgery..... Year _____     |
| <input type="checkbox"/> Hernia repair ..... Year _____               | <input type="checkbox"/> Orthopaedic surgery..... Year _____     |
| <input type="checkbox"/> C-section ..... Year _____                   | <input type="checkbox"/> Orthopaedic surgery..... Year _____     |
| <input type="checkbox"/> Pacemaker ..... Year _____                   | <input type="checkbox"/> Other..... Year _____                   |
| <input type="checkbox"/> Metal implants ..... Year _____              | <input type="checkbox"/> Other..... Year _____                   |
| <input type="checkbox"/> Spine surgery ..... Year _____               | <input type="checkbox"/> Other..... Year _____                   |

**CURRENT MEDICATIONS**

-OR-  No medications

Medication	Strength	How Often?

**ALLERGIES/SENSITIVITIES**

-OR-  No known allergies/sensitivities

Allergic/Sensitive To	Reaction	Allergic/Sensitive To	Reaction
Latex		Other:	
Adhesives/tapes		Other:	
Bees		Other:	
Lotions/creams		Other:	

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

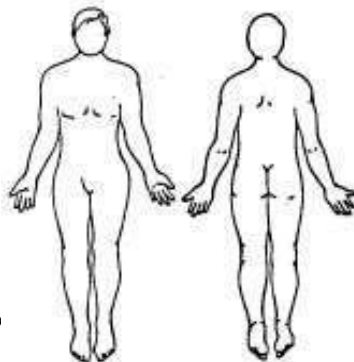
**REVIEW OF SYSTEMS**

Please indicate if you are currently experiencing any of the following conditions:

<b><u>Constitutional</u></b>	<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Foot/ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>		Difficulty rising from low seat	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>							
Unintentional weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Respiratory</u></b>	<b>Y</b>	<b>N</b>		<b><u>Neurological</u></b>	<b>Y</b>	<b>N</b>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>		Tingling/numbness	<input type="checkbox"/>	<input type="checkbox"/>
Profuse sweating	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>		Tremors	<input type="checkbox"/>	<input type="checkbox"/>
			Phlegm production	<input type="checkbox"/>	<input type="checkbox"/>		Speech change	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Skin</u></b>	<b>Y</b>	<b>N</b>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		Hand, arm or leg weakness	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>					Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
			<b><u>Gastrointestinal</u></b>	<b>Y</b>	<b>N</b>		Vertigo/spinning	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Head, Ears, Nose &amp; Throat</u></b>	<b>Y</b>	<b>N</b>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>		Unbalanced/unsteady	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>		Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>				
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>		<b><u>Psychiatric</u></b>	<b>Y</b>	<b>N</b>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		Depression	<input type="checkbox"/>	<input type="checkbox"/>
Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>		Suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>		Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dark tarry stools	<input type="checkbox"/>	<input type="checkbox"/>		Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder incontinence	<input type="checkbox"/>	<input type="checkbox"/>		Nervous/anxious	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>		Sleeping disorder	<input type="checkbox"/>	<input type="checkbox"/>
							Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Eyes</u></b>	<b>Y</b>	<b>N</b>	<b><u>Genitourinary</u></b>	<b>Y</b>	<b>N</b>				
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>		<b>MISCELLANEOUS</b>		
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>		<b><u>Living Environment</u></b>		
Sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>	Frequency	<input type="checkbox"/>	<input type="checkbox"/>		With whom do you live?		
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Alone		
Eye discharge	<input type="checkbox"/>	<input type="checkbox"/>	Side pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Spouse and /or other		
Eye redness	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Child/children at home		
			<b><u>Musculoskeletal</u></b>	<b>Y</b>	<b>N</b>				
<b><u>Cardiovascular</u></b>	<b>Y</b>	<b>N</b>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>		Where do you live?		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Private home		
Pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Assisted living		
Shortness of breath relieved by sitting up	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>				
Shortness of breath during sleep/rest/activity	<input type="checkbox"/>	<input type="checkbox"/>	Falls	<input type="checkbox"/>	<input type="checkbox"/>		How do you rate your general health?		
Calf pain with activity	<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor		
			Lack of coordination	<input type="checkbox"/>	<input type="checkbox"/>				
			Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>				
			Night pain	<input type="checkbox"/>	<input type="checkbox"/>				

**Your current pain: Indicate Do not indicate areas of pain that**

**KEY:** 0000 = Pins &  
xxxx = Burning  
//// = Stabbing  
---- = Numbness



**where your pain is located on the diagram. are not related to your current problem.**

Needles



Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**CURRENT PROBLEM**

Reason for today's visit \_\_\_\_\_ Date of onset \_\_\_\_\_

Is this visit due to injury or accident?  Yes  No Date of injury \_\_\_\_\_ Date of surgery \_\_\_\_\_

What treatment or tests have you had for this current problem?  Surgery  CT  MRI  X-Ray  Injection  Splint/brace

Are you self-medicating with any of the following?  Anti-inflammatory (Ibuprofen/Motrin/Advil)  Acetaminophen (Tylenol)  Other pain medication \_\_\_\_\_

Have you received therapy for the current or other problem in the past year?  Yes  No If yes, indicate below:

	<u>Date</u>	<u># of Visits</u>		<u>Date</u>	<u># of Visits</u>
<input type="checkbox"/> Physical therapy	_____	_____	<input type="checkbox"/> Chiropractor	_____	_____
<input type="checkbox"/> Occupational therapy	_____	_____	<input type="checkbox"/> Massage	_____	_____
<input type="checkbox"/> Speech therapy	_____	_____	<input type="checkbox"/> Acupuncture	_____	_____
<input type="checkbox"/> Skilled nursing facility	_____	_____			

What activities make your pain worse? \_\_\_\_\_  
What activities make your pain better? \_\_\_\_\_  
How far can you walk? \_\_\_\_\_ What stops you? \_\_\_\_\_  
What are you unable to do because of your current problem? \_\_\_\_\_  
Have you had this problem before?  Yes  No If yes, when? \_\_\_\_\_  
What did you do about it? \_\_\_\_\_

Pain rating, on a scale of 0 to 10: 0 = NO PAIN 10 = THE WORST PAIN IMAGINEABLE

How would you rate the intensity of your pain during the last 1 to 2 weeks?

Current:	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Lowest:	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Highest:	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10

Since the problem began, has the problem become:  Worse  Better  Unchanged

What are your goals for treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## INSTRUCTIONS

**Before your first visit, download the patient forms from our website  
[www.myrtw.com/forms](http://www.myrtw.com/forms)**

**On your first visit, please remember to bring the following:**

1. Physician or NPP (Non-Physician Provider) order for therapy.
2. ***Bring the patient forms you filled out***
3. Insurance cards (primary and secondary).
4. Photo ID.
5. Current list of medicines and allergies.
6. Recent reports that you might have, including x-rays, MRI's, surgeries, etc.
7. Loose-fitting, comfortable clothing.
8. Supportive closed-toe shoes.
9. Bring in any adaptive devices currently used, such as braces, canes, walkers, etc.
10. Copy of home health discharge with name and phone number of home health agency if applicable.
11. Notify us of implants and pacemakers (defibrillators).

**Due to allergies of staff members and  
patients, please refrain from  
strong fragrances.**