REHAB THERAPY WORKS

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_____

**********

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

REHAB THERAPY WORKS

**SCREENING FORM**

Patient Name _____ Facility _____

**Effective January 1, 2019, the Medicare "Cap" starts at $2,040 for physical and speech therapy services combined, and $2,040 for occupational therapy services, billed by an outpatient provider. Each provider is required to track the entire therapy episode, regardless of setting. When the Cap exceeds $3,000, there may be additional scrutiny of the claim by Medicare for medical necessity. Services can only be denied for medical necessity reasons.**

## Previous Therapy

1. Since the first of the year, have you received Part B therapy services in a skilled nursing facility?
   □ Yes □ No If yes, by whom and how much? _____
   _____
2. Since the first of the year, have you received Part B therapy services in a physician's office?
   □ Yes □ No If yes, by whom and how much? _____
   _____
3. Since the first of the year, have you received Part B therapy services in an outpatient clinic?
   □ Yes □ No If yes, by whom and how much? _____
   _____
4. Since the first of the year, have you received Part B therapy services in your home? □ Yes □ No
   If yes, by whom and how much? _____
   _____

## Previous Home Health

Are you currently receiving home health services for nursing, or physical, occupational or speech therapy, from a home health agency? □ Yes □ No

*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 _____

REHAB THERAPY WORKS

# 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)

REHAB THERAPY WORKS

Patient Name_____ Date_____

## PAST MEDICAL HISTORY

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

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blood disorders
☐ Blood transfusion
☐ Cancer
☐ Congestive heart failure
☐ Nerve/muscle disease
☐ Lung disease
☐ Meningitis
☐ Depression
☐ HIV/AIDS
☐ Kidney disease
☐ Diabetes mellitus
☐ Clotting disorder (blood clot)
☐ High blood pressure
☐ Acid reflux
☐ Glaucoma
☐ Gout
☐ Heart attack
☐ High cholesterol
☐ Osteoporosis
☐ Seizures
☐ Sickle cell anemia
☐ Stroke
☐ Substance abuse
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers
☐ Cataracts
☐ Other_____
_____
_____

**For men only**: Have you been diagnosed with prostrate disease? ☐ Yes ☐ No

**For women only**: Have you ever been diagnosed with any of the following? (Check all that apply)
☐ Pelvic inflammatory disease
☐ Endometriosis
☐ Trouble with your period
☐ Complicated pregnancies or deliveries
☐ Pregnant or think you may be
☐ Other gynecological or obstetrical difficulties? If yes, please describe_____
_____
_____

## PAST SURGICAL HISTORY

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

☐ Breast surgery ..... Year_____
☐ Open heart or bypass surgery..... Year_____
☐ Gall bladder ..... Year_____
☐ Colon surgery..... Year_____
☐ Fracture surgery ..... Year_____
☐ Hernia repair ..... Year_____
☐ C-section ..... Year_____
☐ Pacemaker ..... Year_____
☐ Metal implants ..... Year_____
☐ Spine surgery ..... Year_____
☐ Tubes tied ..... Year_____
☐ Hysterectomy..... Year_____
☐ Heart valve replacement..... Year_____
☐ Orthopaedic surgery_____...Year_____
☐ Orthopaedic surgery_____...Year_____
☐ Orthopaedic surgery_____...Year_____
☐ Orthopaedic surgery_____...Year_____
☐ Other_____...Year_____
☐ Other_____...Year_____
☐ 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: | |

REHAB THERAPY WORKS

Patient Name_____ Date_____

## REVIEW OF SYSTEMS

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

| **Constitutional** | **Y** | **N** |
|---|---|---|
| Fever | ☐ | ☐ |
| Chills | ☐ | ☐ |
| Unintentional weight loss | ☐ | ☐ |
| Fatigue | ☐ | ☐ |
| Profuse sweating | ☐ | ☐ |

| **Skin** | **Y** | **N** |
|---|---|---|
| Rash | ☐ | ☐ |
| Itching | ☐ | ☐ |

| **Head, Ears, Nose & Throat** | **Y** | **N** |
|---|---|---|
| Headaches | ☐ | ☐ |
| Hearing loss | ☐ | ☐ |
| Ringing in ears | ☐ | ☐ |
| Ear pain | ☐ | ☐ |
| Ear discharge | ☐ | ☐ |
| Nose bleeds | ☐ | ☐ |
| Congestion | ☐ | ☐ |
| Wheezing | ☐ | ☐ |
| Sore throat | ☐ | ☐ |

| **Eyes** | **Y** | **N** |
|---|---|---|
| Blurred vision | ☐ | ☐ |
| Double vision | ☐ | ☐ |
| Sensitive to light | ☐ | ☐ |
| Eye pain | ☐ | ☐ |
| Eye discharge | ☐ | ☐ |
| Eye redness | ☐ | ☐ |

| **Cardiovascular** | **Y** | **N** |
|---|---|---|
| Chest pain | ☐ | ☐ |
| Pounding heart | ☐ | ☐ |
| Shortness of breath relieved by sitting up | ☐ | ☐ |
| Shortness of breath during sleep/rest/activity | ☐ | ☐ |
| Calf pain with activity | ☐ | ☐ |
| Foot/ankle swelling | ☐ | ☐ |

| **Respiratory** | **Y** | **N** |
|---|---|---|
| Cough | ☐ | ☐ |
| Coughing up blood | ☐ | ☐ |
| Phlegm production | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Wheezing | ☐ | ☐ |

| **Gastrointestinal** | **Y** | **N** |
|---|---|---|
| Heartburn | ☐ | ☐ |
| Nausea | ☐ | ☐ |
| Vomiting | ☐ | ☐ |
| Stomach pain | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Blood in stool | ☐ | ☐ |
| Dark tarry stools | ☐ | ☐ |
| Bladder incontinence | ☐ | ☐ |
| Bowel incontinence | ☐ | ☐ |

| **Genitourinary** | **Y** | **N** |
|---|---|---|
| Painful urination | ☐ | ☐ |
| Urgency | ☐ | ☐ |
| Frequency | ☐ | ☐ |
| Blood in urine | ☐ | ☐ |
| Side pain | ☐ | ☐ |

| **Musculoskeletal** | **Y** | **N** |
|---|---|---|
| Muscle pain | ☐ | ☐ |
| Neck pain | ☐ | ☐ |
| Back pain | ☐ | ☐ |
| Joint pain | ☐ | ☐ |
| Falls | ☐ | ☐ |
| Weakness in arms or legs | ☐ | ☐ |
| Lack of coordination | ☐ | ☐ |
| Difficulty walking | ☐ | ☐ |
| Night pain | ☐ | ☐ |
| Difficulty rising from low seat | ☐ | ☐ |

| **Neurological** | **Y** | **N** |
|---|---|---|
| Tingling/numbness | ☐ | ☐ |
| Tremors | ☐ | ☐ |
| Speech change | ☐ | ☐ |
| Hand, arm or leg weakness | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Loss of consciousness | ☐ | ☐ |
| Vertigo/spinning | ☐ | ☐ |
| Unbalanced/unsteady | ☐ | ☐ |
| Lightheadedness | ☐ | ☐ |

| **Psychiatric** | **Y** | **N** |
|---|---|---|
| Depression | ☐ | ☐ |
| Suicidal ideas | ☐ | ☐ |
| Substance abuse | ☐ | ☐ |
| Hallucinations | ☐ | ☐ |
| Nervous/anxious | ☐ | ☐ |
| Sleeping disorder | ☐ | ☐ |
| Memory loss | ☐ | ☐ |

**MISELLANEOUS**

**Living Environment**

With whom do you live?

☐ Alone
☐ Spouse and /or other
☐ Child/children at home

Where do you live?

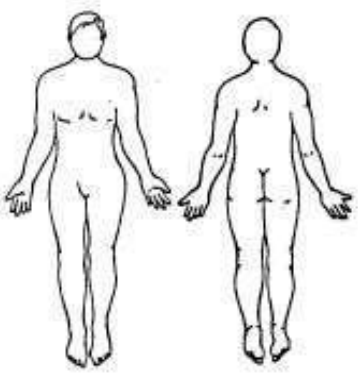
☐ Private home
☐ Assisted living

How do you rate your general health?

☐ Good ☐ Average ☐ Poor

**Your current pain: Indicate where your pain is located on the diagram.**
**Do not indicate areas of pain that are not related to your current problem.**

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



REHAB THERAPY WORKS

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:

| | Date | # of Visits | | Date | # of Visits |
|---|---|---|---|---|---|
| ☐ Physical therapy | | | ☐ Chiropractor | | |
| ☐ Occupational therapy | | | ☐ Massage | | |
| ☐ Speech therapy | | | ☐ Acupuncture | | |
| ☐ 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: | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| Lowest: | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| Highest: | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |

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

What are your goals for treatment?_____
_____
_____

Signature_____Date_____

Signature_____Date_____

Signature_____Date_____

REHAB THERAPY WORKS

**INSTRUCTIONS**

**Before your first visit, download the patient forms from our website 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.**