REHABILITATION SERVICE MEDICAL HISTORY

Name: _____ Date: _____

Do you have an Advanced Directive? ☐ Yes ☐ No

Primary Language for health care concerns? _____

Do you have allergies to medications or food? ☐ None Allergy: _____

Describe reaction: _____

Current or Past Medical History (please mark all that apply)

____Difficulty swallowing	____Stroke	____Arthritis	____Diabetes
____High blood pressure	____Blood Clots	____Anemia	____Supplemental 02 use
____Pacemaker	____Shortness of breath	____Cancer	
____Frequent falls	____Dizziness	____Heart problems/angina	
____Urinary Incontinence	____Osteoporosis	____Epilepsy/seizures	

History of Current Problems that you are seeking therapy services for:

Date of injury or onset for your symptoms/problems? _____

How did it happen? _____

_____

Have you previously had a similar problem? ☐ Yes ☐ No

List any diagnostic studies you have had for this problem: _____

_____

Have you ever had therapy for this condition? ☐ Yes ☐ No

Did it help? ☐ Yes ☐ No

Are you limited at your job or household duties? ☐ Yes ☐ No If yes, please describe: _____

_____

List any previous surgeries: _____

_____

What results are you hoping from your therapy? _____

_____

For patients 65 and over:

Have you fallen in the last year? ☐ Yes ☐ No

Are you afraid of falling? ☐ Yes ☐ No

Thank you for taking the time to fill out this form as completely as possible. It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

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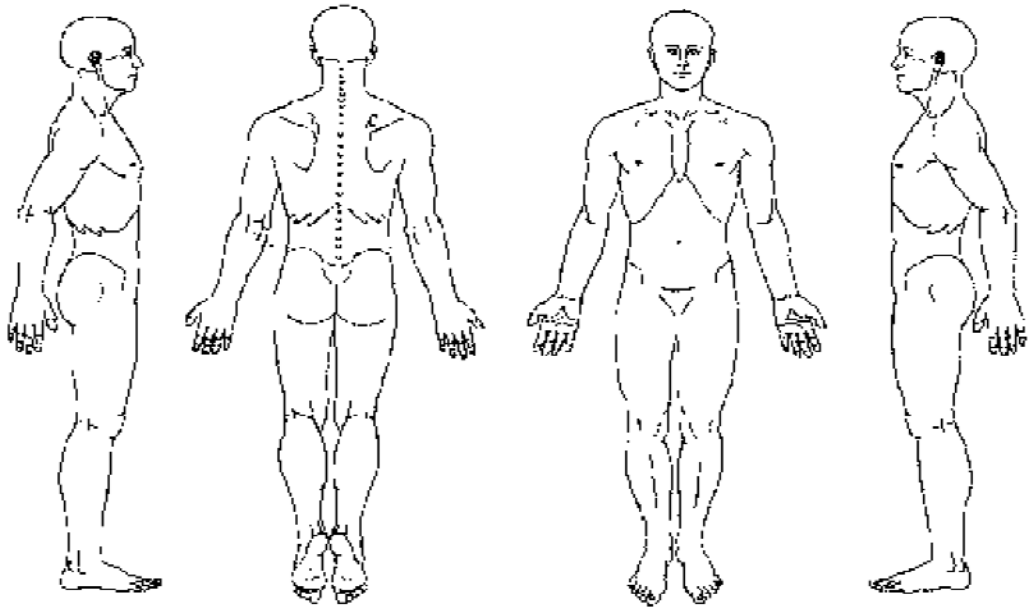
Circle your problem area and any other area that you or your provider have discussed:



Do you have any other orthopedic problems?

REHABILITATION SERVICE MEDICAL HISTORY

Let's work together

Marshall Medical Center's Rehabilitation Services strives to provide you the best personalized care available. Your successful rehabilitation depends not only on the skill of your Physical Therapist, but on your commitment, attendance and follow through. To make this possible, we ask that you make every effort to comply with our guidelines below.

Please read and initial all boxes below and sign at the bottom, indicating you have read and understood the information.

_____ **24 - Hour Advance Notice** – If you wish to change or cancel an appointment we request the courtesy of a 24-hour notice. The therapist's time is set aside exclusively for you. Advance notice allows someone else who may be waiting the time to reserve the appointment in your place.

_____ **No Show** – Attendance at therapy is critical to a successful outcome. If you fail to show up for two appointments without notice, all future scheduled appointments will be cancelled and you will need to call to reschedule. On the 3rd no show, your chart will be discharged and a note sent to your physician.

_____ **Late Policy** – If you are going to be late, we ask that you notify our office. Your therapist may have to shorten your treatment time or reschedule the appointment if you are more than 10 minutes late.

_____ **Copays are due upon arrival** – Please come prepared to pay your copay at the time of service. Marshall offers a discount on the full bill for those who consistently make their co-payment at the time of service.

_____ **Financial Hardship** – If you are experiencing financial difficulties and are unable to afford the cost of services, Marshall has financial assistance programs that may help. Please ask the front desk for assistance.

_____ **Cell phones must be OFF or silent** – We realize emergencies may arise and so be courteous and set to silent or vibration mode during your therapy session.

Thank you for taking the time to read and understand our policy. If you have any questions, please do not hesitate to discuss them with your therapist.

We look forward to partnering with you for a successful outcome!

Patient Signature: _____ Date: _____ Time: _____