Middlesex Health

CC4653

PHYSICAL REHABILITATION

Patient Name:_____ DOB:_____

Reason for Seeking Therapy:_____

Date Symptoms Began?_____

Past Medical History (Please check all that apply):

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bowel/Bladder Problems
- ❑ Blood Pressure Problems
- ❑ Cancer
- ❑ Clotting Disorder
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ DVT
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ GERD
- ❑ Headaches
- ❑ Hearing Problems
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Lung Problems
- ❑ Neurological Disorder
- ❑ Pancreatic Disease
- ❑ Psychological Problems
- ❑ Swelling/Edema
- ❑ Sleep Disorder
- ❑ Thyroid Disorder
- ❑ Vision Problems
- ❑ Weight Changes
- ❑ Wounds
- ❑ Other: _____
- ❑ _____

Surgical History and Hospitalizations: ❑ None

_____

Medications: ❑ None ❑ Copy provided/see attached: _____

_____

_____

Allergies: ❑ None_____

Pain Scale: Rate your pain today (Circle): **0——1——2——3——4——5——6——7——8——9——10**

No Pain **Worst Pain**

Goals and Consent

At the end of my first visit, my therapist and I will discuss treatment options, including risks, benefits, and plans for treatment. I understand that my therapist and I will work together to meet these goals. **I agree (Initial each section below):**

- _____ To keep all of my appointments, or call at least 24 hours in advance if I need to cancel. If I miss two appointments in a row without calling to cancel, my name will be taken out of the schedule and I may need a new doctor's referral to continue therapy. If I am on worker's compensation and miss my appointment, my employer can be notified.
- _____ If I am late for my appointment, my therapist may see me if there is enough time in the schedule.
- _____ I may receive care from another therapist if my therapist is unavailable.
- _____ To do my home exercises and follow any instructions that my therapist gives me.
- _____ To tell my therapist if I have any changes in health and/or medication, or if I see another doctor for the same condition.
- _____ My therapy will end when I have met all my goals or when my therapist and I find that we have reached the highest possible benefit of therapy. Therapy can also end due to a change in my health, lack of insurance, or if I stop coming for treatment.
- _____ It is my responsibility to check my insurance coverage for Outpatient Hospital/Facility based therapy services.

My Goals for Therapy: _____

_____

_____ _____ _____

Patient/Guardian Signature **Date** **Time**

FOR OFFICE USE ONLY

SAFETY/FALL RISK: ❑ Age 65 or older ❑ 3 or more co-existing diagnoses ❑ History of falls within 3 months ❑ Incontinence ❑ Visual Impairments ❑ Impaired Functional Mobility ❑ 4 or more medications ❑ Cognitive Impairment ❑ Pain Affecting Function

Score: _____ (4 or more = Risk of falling) ❑ No Telehealth

_____ _____ _____

Therapist Signature **Date** **Time**