

MEDICAL HISTORY FORM

Patient's name: _____ Date: _____

Physician's name: _____ Date of next physician's visit: ____/____/____

BACKGROUND INFORMATION

Reason for which you are seeking therapy: _____

Date of injury/onset: ____/____/____ Have you ever had these symptoms before? Yes No

Have you been hospitalized because of this condition? Yes (Admission date_____ Discharge date_____) No

Please describe the current problem that brings you to therapy, including when and how the problem first occurred:

Prior to the onset of this condition, did you have any difficulty in the areas for which you are now seeking therapy?

Yes No If yes, please describe _____

Please describe any previous therapy or treatment: _____

What goals would you like to achieve in therapy? _____

Who is the main physician working with you to manage this condition? _____

Is this physician the same as the referring physician? Yes No

Would you like assistance finding medical professionals to manage this or other medical conditions? Yes No

If "yes", what medical condition do you need further assistance managing? _____

Are you presently taking medication (including prescription, over-the-counter and herbal)? Yes No

If yes, please list all medications:

Please list any foods, medications, etc. that you are allergic/sensitive to:

Are you allergic to latex? Yes No



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PATIENT LABEL

It is very important that we have a complete medical history so that we can better serve you. Please fill in "other" for any conditions, injuries, or surgeries not listed below.

Do you have, or have you ever had any of the following?

| | | | | | |
|-------------------------------|-----|----|------------------------------------|-----|----|
| Diabetes | Yes | No | Recent upper respiratory infection | Yes | No |
| Chest pain/angina | Yes | No | Poor tolerance to heat | Yes | No |
| High blood pressure | Yes | No | Poor tolerance to cold | Yes | No |
| Heart attack | Yes | No | Any accident resulting in trauma | Yes | No |
| Heart palpitations | Yes | No | Recent fractures | Yes | No |
| Pacemaker | Yes | No | Surgeries | Yes | No |
| Stroke | Yes | No | Metal implants | Yes | No |
| Brain injury | Yes | No | Dizziness/fainting | Yes | No |
| Neurological disease | Yes | No | Bowel/bladder abnormalities | Yes | No |
| Seizures | Yes | No | Are you pregnant? | Yes | No |
| Headaches | Yes | No | ringing in your ears | Yes | No |
| Cancer | Yes | No | Nausea/vomiting | Yes | No |
| Osteoporosis | Yes | No | Mental health problems | Yes | No |
| Skin abnormalities | Yes | No | Hypoglycemia | Yes | No |
| Asthma/breathing difficulties | Yes | No | Acid reflux/GERD | Yes | No |
| Liver/gallbladder problems | Yes | No | Difficulty chewing or swallowing | Yes | No |
| Kidney problems | Yes | No | Special diet guidelines | Yes | No |
| Hernia | Yes | No | Other _____ | | |
| Rheumatoid arthritis | Yes | No | Other _____ | | |

For all "yes" responses above, please briefly explain and give the approximate dates:

Have you been on antibiotics within the last month? Yes No

If so, for what? _____

Have you tested positive for TB? Yes No

If so, has it been treated and cleared? _____

Have you tested positive for any other communicable infections? (e.g. C-Diff, MRSA, shingles, VRE, ESBL, hepatitis, etc.) If so please list them:

Have you fallen in the last 6 months? Yes No If so, number of times _____

Do you have any difficulty with thinking skills such as memory, attention, or problem solving? Yes No

If yes, please explain _____



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PATIENT LABEL

Do you have any difficulty communicating, such as difficulty speaking, finding your words, or understanding what others say? Yes No If yes, please explain:

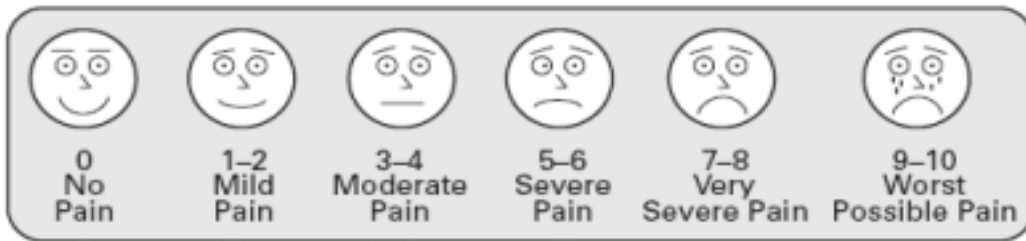
Do you have an advance directive? Yes No
If yes, please provide a copy. If you need more information, please contact your physician or attorney.

Do you now or have you in the past smoked? Yes No
If yes, for how long? _____ How much? _____

Do you now or have you in the past drank alcohol? Yes No
If yes, how much? _____ How often? _____

PAIN

On a scale of 1-10, using the pictures, what is your pain level? 0 1 2 3 4 5 6 7 8 9 10



WORK HISTORY

What is/was your profession? _____

What is your present work status?

- Full time/regular Full time/modified Not working Retired
- Part time/regular Part time/modified Not working but plan to return On disability (date)

Describe the requirements of your job and/or daily routine. (Speech therapy patients: include communication requirements.)

LEARNING NEEDS

Is English your primary language? Yes No If no, what is your primary language? _____

Please describe any hearing or vision limitations you may have. _____

What is your educational background? Grade school High school College Advanced degree



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PATIENT LABEL

Please describe what you would like to learn about your therapy or condition.

How do you learn best? Verbal instruction Demonstration Written handouts Pictures

CULTURAL/RELIGIOUS INFORMATION (OPTIONAL)

Please describe any cultural/religious beliefs or values that we should take into consideration during your treatment:

What is your faith tradition/denomination: _____

Would you like a chaplain to contact you for emotional or spiritual support?

Yes (telephone number : _____) No

SOCIAL INFORMATION

What is your marital status? Single Married Significant other Separated Divorced Widowed

Do you have any children? Yes No If yes, how many? _____

Do you currently live with anybody? Yes No If yes, who? _____

Who is most involved in helping you recover from your condition? _____

Where do you currently reside? Home Skilled Nursing Facility Assisted Living Long Term Care/Nursing Home

Do you receive any services in your current residence? Nursing Therapy Social Worker Personal Assistance

What community activities are you having difficulty with since your injury/illness?

The consultative services of a social worker are available through Adventist Rehabilitation Hospital. Would you like to use these services? Yes No

ADDITIONAL INFORMATION

Please provide any additional information that would be helpful for us to have.

Patient Signature: _____ Date: _____



PATIENT LABEL

CONSENT TO TREAT

I do hereby consent to evaluation and treatment by Adventist Rehabilitation Hospital of Maryland (ARHM) out-patient therapy department and their affiliates. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment. An individual who is to receive therapy services at ARHM's out-patient therapy department will be registered and remain under the care of his/her attending physician and all hospital staff for the care and treatment of his/her condition. The patient consents to any treatments, examinations, diagnostic tests, specialized therapies, and other medical interventions deemed fully necessary under the direction of an attending physician or licensed therapist. The patient also recognizes that all physicians that consult and furnish services ordered by the attending physician are independent contractors and are privileged by the hospital to provide such services. Neither the hospital nor any of its components are liable if the patient does not follow plan of care/instructions of his/her attending physician.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE AND RECEIVED COPIES THEREOF, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S LEGAL REPRESENTATIVE, TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Patient/Legal Representative

Relationship to Patient

Date

Hospital Representative

Date



OUTPATIENT FINANCIAL AGREEMENT AND DISCLOSURES

Adventist Rehabilitation Hospital of Maryland (ARHM) originates and maintains health records describing your health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. A notice of our privacy practices describing how your information may be used and disclosed as well as how you can get access to this information is provided in your Welcome Packet.

_____ I have been provided with a *Notice of Health Information Practices* that provides a more complete description of information uses and disclosures.

_____ I have received a copy of the *Rights and Responsibilities* and have been informed of all procedures governing patient conduct and responsibilities. Adventist Rehabilitation Hospital of Maryland (ARHM) may disclose all or any part of my medical record to any person or corporation in order to facilitate reimbursement for services including but not limited to hospitals or medical service companies, consulting & referring physicians, insurance companies, or their contracting review agencies, worker's compensation carriers, welfare funds and other government insurance companies. This release is strictly for reimbursement purposes to ARHM for services rendered.

I, _____, agree to direct payment to ARHM of any insurance benefits otherwise payable to me for the out-patient services I receive. In the event that any other insurance plans or carriers do not reimburse ARHM, I agree to pay all charges and associated incidental charges not covered by my insurance plans.

Payment plans can be arranged through the Business Office if deemed necessary. ARHM provides an estimate of charges as a courtesy; however it is recommended that you verify your payment responsibility with your insurance carrier.

Signature of Patient or Guardian

Date

Hospital Representative

Date



Form 338 OP Financial Agreement



PATIENT LABEL

Outpatient Services

DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility or the Central Billing Office to inquire about your personal health information or billing information. Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues. Please take a few moments to complete this form.

I authorize Adventist Rehabilitation to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

| Name | Relationship |
|------|--------------|
| | |
| | |
| | |
| | |

I wish to be contacted in the following manner: Home _____ Work _____
 Cell _____ Written Communication E-Mail/Other _____

I grant ARHM and its affiliates permission to leave a message on my voicemail regarding appointments/information with detailed information: YES NO

To mail to my home/work address To fax to this number _____

Signature of Patient/Legal Representative

Date

Print Name of Patient or Representative

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

- Healthcare Power of Attorney Guardian Spouse
 Legal Representative Parent Other _____

Please provide documentation or an explanation of your authority to act on behalf of the patient:



The Activities-specific Balance Confidence (ABC) Scale*

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

| | | | | | | | | | | | |
|---------------|----|----|----|----|----|----------------------|----|----|----|------|--|
| 0% | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100% | |
| no confidence | | | | | | completely confident | | | | | |

“How confident are you that you will not lose your balance or become unsteady when you...

- 1) ...walk around the house? ____ %
- 2) ...walk up or down stairs? ____ %
- 3) ...bend over and pick up a slipper from the front of a closet floor ____ %
- 4) ...reach for a small can off a shelf at eye level? ____ %
- 5) ...stand on your tiptoes and reach for something above your head? ____ %
- 6) ...stand on a chair and reach for something? ____ %
- 7) ...sweep the floor? ____ %
- 8) ...walk outside the house to a car parked in the driveway? ____ %
- 9) ...get into or out of a car? ____ %
- 10) ...walk across a parking lot to the mall? ____ %
- 11) ...walk up or down a ramp? ____ %
- 12) ...walk in a crowded mall where people rapidly walk past you? ____ %
- 13) ...are bumped into by people as you walk through the mall? ____ %
- 14) ... step onto or off an escalator while you are holding onto a railing? ____ %
- 15) ... step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____ %
- 16) ...walk outside on icy sidewalks? ____ %

**Powell, LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. J Gerontol Med Sci 1995; 50(1): M28-34*



Form 306 Activities Specific Balance



PATIENT LABEL

Date: _____

IE DC

Author: Jan Weiss PT, MHS
CoxHealth
Springfield, MO

Lymphedema Quality of Life Questionnaire

Listed below are symptoms or problems many individuals with lymphedema report. Please indicate to what extent these problems associated with your lymphedema have affected you in the past 2 weeks. Circle one number; #1 indicates no complaint and #5 the most severe complaint.

I. Physical concerns

1. The amount of pain associated with my lymphedema is:

| | | | | |
|---------|---|---|---|-------------|
| 1 | 2 | 3 | 4 | 5 |
| no pain | | | | severe pain |

2. The amount of limb heaviness associated with my lymphedema is:

| | | | | |
|--------------|---|---|---|-----------------|
| 1 | 2 | 3 | 4 | 5 |
| no heaviness | | | | extremely heavy |

3. The amount of skin tightness associated with my lymphedema is:

| | | | | |
|--------------|---|---|---|-----------------|
| 1 | 2 | 3 | 4 | 5 |
| no tightness | | | | extremely tight |

4. In comparison to my unaffected limb, the size of my swollen limb seems:

| | | | | |
|-----------|---|---|---|-----------------|
| 1 | 2 | 3 | 4 | 5 |
| same size | | | | extremely large |

5. In comparison to my unaffected limb, the skin texture of my swollen limb feels:

| | | | | |
|----------|---|---|---|---------------------|
| 1 | 2 | 3 | 4 | 5 |
| the same | | | | extremely different |

6. Lymphedema affects movement of my swollen limb:

| | | | | |
|-----------------|---|---|---|--------------------------|
| 1 | 2 | 3 | 4 | 5 |
| normal movement | | | | movement greatly limited |

7. The strength in my swollen limb compared with the unaffected limb is:

1 2 3 4 5
equal extremely
strength weak

8. How often have you become ill with an infection in your swollen limb requiring oral antibiotics or hospitalization **in the past 2 years**.

1 2 3 4 5
never <1x/yr 1-3x/yr 4-6x/yr 7-9x/yr

II. Psychosocial Concerns

9. Lymphedema affects my body image (ie. “how I think I look”):

1 2 3 4 5
not at all severely

10. Lymphedema affects my socializing with others:

1 2 3 4 5
no interference interferes completely

11. Lymphedema affects my intimate relations:

1 2 3 4 5
no interference interferes completely

12. Lymphedema “gets me down” (i.e. feelings of depression, frustration, or anger due to the lymphedema):

1 2 3 4 5
never constantly

III. Functional Concerns

13. Lymphedema affects my ability to perform duties at home:

1 2 3 4 5
no interference interferes completely

14. Lymphedema affects my ability to perform duties at work: (If applicable).



Form 336 Lymphedema QOL



PATIENT LABEL

1 2 3 4 5
No interference interferes completely

15. Lymphedema affects my performance of preferred recreational activities:

1 2 3 4 5
No interference interferes completely

16. Lymphedema affects the proper fit of clothing/shoes:

1 2 3 4 5
Fits normally unable to wear

17. Lymphedema affects my sleep:

1 2 3 4 5
No interference interferes completely

18. I must rely on others for help due to my lymphedema:

1 2 3 4 5
Not at all completely



Form 336 Lymphedema QOL