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

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_____

_____

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

_____

_____

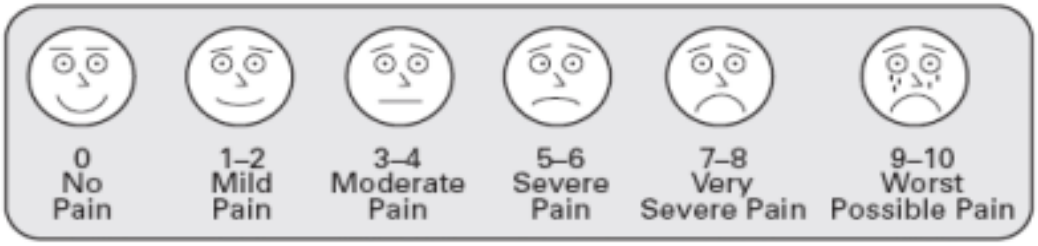
Do you have an advance directive? Yes No
If yes, please provide a copy. If you need more information, please contact your physician or attorney.

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

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: _____

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

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 <u>each</u> 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 <u>not</u> 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

Date:_____ □ **IE** □ **DC**

Adventist Quality of Life Questionnaire (AQLQ)

Please rate your quality of life since you illness/injury in the following areas, using a "0" to "100" scale, where "0" indicates that you are very dissatisfied and "100" means you are very satisfied (e.g. feel similar to how you felt before your illness/injury).

Rate you satisfaction with:

1. Your relationships and interactions with your friends and family:

0 10 20 30 40 50 60 70 80 90 100
Very dissatisfied Very satisfied

2. Work/Community participation:

0 10 20 30 40 50 60 70 80 90 100
Very dissatisfied Very satisfied

3. Participation in and quality of leisure time/activities:

0 10 20 30 40 50 60 70 80 90 100
Very dissatisfied Very satisfied

4. Your self-identity and self-perception:

0 10 20 30 40 50 60 70 80 90 100
Very dissatisfied Very satisfied

5. Your overall quality of life:

0 10 20 30 40 50 60 70 80 90 100
Very dissatisfied Very satisfied