OUTPATIENT REGISTRATION QUERIES

- I understand that it is my responsibility to contact my insurance company to verify outpatient therapy coverage, and to confirm my deductible amount and/or co-pay.

- I have received physical therapy/ occupational therapy/ speech therapy since January of this year.
  - Yes
  - No

  Or: I have received physical therapy/ occupational therapy/ speech therapy during the last 12 months.
  - Yes
  - No

- I am presently receiving Home Health Care.
  - Yes
  - No

- Please provide your cell phone number: ________________________________

- Please be aware that all co-pays are due at the time of each appointment.

CANCELLATION POLICY

Your therapist and physician will determine a frequency of treatment that will most effectively meet your specific needs and achieve the best results. We ask for your commitment to your treatment program by scheduling appointments at a time that you will be able to keep them. If you find that you are unable to keep your appointment because of conflicts in your schedule or due to illness, please notify us 24-hours prior to your appointment. At that time, we will reschedule you for another time that week. Cancelled appointments or inconsistent attendance for scheduled appointments often prevents us from providing the best care possible, and providing care to others.

- Two consecutive cancellations or two consecutive no-shows (without notification) may result in termination from the treatment program.

- If appointments are missed due to a change in medical status, it is essential that you see a physician prior to returning to therapy.

- If you are in significant pain or discomfort, rather than cancel an appointment, it is even more important to attend your appointment to specifically address such discomfort, or make changes in your treatment plan, if necessary.

- Please note that we reserve the right to withhold treatment at any time if the therapist feels your safety is in question and/or we cannot successfully treat you due to apparent substance abuse prior to your scheduled appointment.

__________________________________________
Signature of Patient/Personal Representative
(If Personal Representative, please indicate relationship to patient)

_________   ____________
Date       Time
NAME: ________________________________  DATE: ________________________________

Primary Care Physician: ________________________________  Date of Birth: ________________________________

The purpose of this questionnaire is to assist us in gathering health information important to the evaluation and care planning process. This questionnaire becomes part of your confidential medical record.

CHIEF PROBLEM OR COMPLAINT:

WHAT ARE YOUR REHABILITATION GOALS?

HAVE YOU EVER HAD THERAPY BEFORE?

ALLERGIES:
Are you allergic to latex?  YES  NO

Please list any allergies including medication sensitivities:

MEDICATIONS:
Please list all medical & orthopedic medications you are taking:  * Please notify your therapist of any changes.*

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<th>NOW</th>
<th>PAST (orthopedic only)</th>
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Please list any herbal supplements you are now taking:  YES  NO

ARE YOU ON OXYGEN?  YES  NO

HAVE YOU BEEN HOSPITALIZED IN THE PAST 5 YEARS?  YES  NO

If yes, why?

HAVE YOU EVER HAD SURGERY?  YES  NO

If yes, please list all procedures:

HAVE YOU EVER HAD A CT SCAN OR A MRI?  YES  NO

Do you have or have you had any of the following:

YES  NO  Emphysema/COPD  YES  NO  Bowel/Bladder Problem

YES  NO  Chronic Bronchitis  YES  NO  Diabetes

YES  NO  Tuberculosis  YES  NO  Cancer

YES  NO  Blood Pressure Problem  YES  NO  Seizures

YES  NO  Pacemaker  YES  NO  Hearing Problems

YES  NO  Angina  YES  NO  Vision Problems

YES  NO  Heart Problems  YES  NO  Are you Pregnant?

YES  NO  Stroke/Neurological Condition  YES  NO  Recent Weight Gain/Loss

YES  NO  Sprain, Strains, Hemiations, Fractures  How much?

YES  NO  Orthopedic Problems  YES  NO  Arthritis/Osteoporosis/Fibromyalgia

DO YOU HAVE ANY OTHER STRESS FACTORS THAT ARE PRESENTLY INTERFERING WITH YOUR MEDICAL CONDITION/REHABILITATION GOALS?  YES  NO

WOULD YOU LIKE TO TALK WITH A SOCIAL WORKER?  YES  NO

IF YOU ARE BEING ABUSED OR SUBJECT TO DOMESTIC VIOLENCE, WE CAN HELP.
Please let your therapist know at any time if you need confidential, secure assistance or if you have questions.

Signature of Patient/Personal Representative  ________________________________  Date  ________________________________  Time  ________________________________

(If Personal Representative, please indicate relationship to patient)