NPT
NORWOOD PERFORMANCE THERAPY
An Affiliate of Norwood Hospital

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 Date Time
(If Personal Representative, please indicate relationship to patient)

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HEALTH HISTORY & ASSESSMENT INFORMATION

Name: ______________________ **Date:** ______________________

Primary Care Physician: ______________________

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.****

NOW	PAST (orthopedic only)

Please list any herbal supplements you are now taking: ______________________

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 O NO O Emphysema/COPD

YES O NO O Chronic Bronchitis

YES O NO O Tuberculosis

YES O NO O Blood Pressure Problem

YES O NO O Pacemaker

YES O NO O Angina

YES O NO O Heart Problems

YES O NO O Stroke/Neurological Condition

YES O NO O Sprain, Strains, Herniations, Fractures

YES O NO O Orthopedic Problems

YES O NO O Bowel/Bladder Problem

YES O NO O Diabetes

YES O NO O Cancer

YES O NO O Seizures

YES O NO O Hearing Problems

YES O NO O Vision Problems

YES O NO O Are you Pregnant?

YES O NO O Recent Weight Gain/Loss

How much?

YES O NO O 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 SUBJECTED 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

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