

## PATIENT REGISTRATION FORM

Welcome to our center. In order to serve you properly, we will need the following information. (PLEASE PRINT)			
Patient's Name	Sex M ( ) F ( )	Birth Date ____/____/____ Age _____	Marital Status Single ( ) Married ( ) Widowed ( ) Divorced ( )
Residence address      City      State      Zip	Home Phone ( ) - -		Patient's Social Security# - - -
Person financially responsible for this account	Self ( ) Spouse ( )	Responsible Party's Birth Date / /	Responsible Party's Social Security# - - -
Responsible party's Drivers License# State      Number	Occupation		How long at the current employer?
Name of Employer      Address			Business Phone Number
Referred by: (include address and phone number)			
Person to contact in case of emergency:		Phone number	Relationship to patient
INSURANCE INFORMATION			
Medicare YES ( ) NO ( )			MEDICARE#
Effective Date			
Secondary Insurance Name      Address		Policy#	Effective Date
Subscriber's Name      Address		Group#	Phone Number
Subscriber's Date of Birth		Relationship to patient	
Subscriber's Social Security Number			
Worker's Compensation	Date of Accident Claim number	Carrier's name and address	Carrier's phone number Authorization number
Personal Injury Accident YES ( ) NO ( )	Date of Accident Claim number	Carrier's name and address	Carrier's phone number Authorization number
Attorney's Name		Phone number	Address
<b>Assignment of Benefits / Information Release / Authorization to Treat:</b>  I authorize payment of medical benefits for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.  I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.  I have received a copy of my Patients Rights and Responsibilities and this facility's Grievance Procedure.			
Patient's signature _____		Date _____	
Patient's Parent, Guardian's Signature (if child is under 18 years old) _____		Date _____	

# Patient Consent Form

## Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we make the Notice available to you.

When you sign and date this form you are agreeing that you were given a copy of this notice.

The notice states that we may use and disclose protected health information about you for your treatment, payment, and healthcare operations. In your notice, there is a complete list of examples of how we may use to disclose your personal health information without specific authorization from you.

Do we have your permission to:

Leave a message on your answering machine at home?	Yes	No
Leave a message with someone at home? With whom: _____	Yes	No
Leave a message at your place of work?	Yes	No N/A

Other than your doctor, please list full name and relationship of individual with whom we may discuss your medical condition:

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Patient Name: \_\_\_\_\_

Patient/patient representative Signature:

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

## Summary of Patient's Rights and Responsibilities

We are committed to serving you with compassion, care, skill and respect. As one of our patients, you have choices, rights and responsibilities.

### You have the ***RIGHT***:

- To be treated with dignity and respect
- To know the names and professional status of people serving you
- To privacy
- To confidentiality of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side effects and problems of all forms of treatment
- To participate in choosing a form of treatment
- To receive education and counseling
- To consent to, or refuse, any care of treatment
- To select and or change your health care provider
- To review your medical records
- To information about services and any related costs

### You also have the ***RESPONSIBILITY***

- To seek medical attention promptly
- To be honest about your medical history
- To ask about anything you do not understand
- To follow health advice and medical instructions
- To report any significant changes in symptoms or failure to improve\to respect clinic policies
- To keep appointments or cancel I advance\to seek non-emergency care during regular business hours
- To provide useful feedback about services and policies

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Signature

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Date

# MEDICAL HISTORY FORM

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

PLEASE TELL US A LITTLE ABOUT YOUR SYMPTOMS

Age: \_\_\_\_\_

Do you get short of breath?  yes  no

Activities that cause the shortness of breath:

- |  |  |
|--|--|
| <input type="checkbox"/> Walking         | <input type="checkbox"/> Exercising                                |
| <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Carrying thing such as Groceries, laundry |
| <input type="checkbox"/> Lying Down      | <input type="checkbox"/> Talking                                   |
| <input type="checkbox"/> Cooking         | <input type="checkbox"/> Cleaning                                  |
| <input type="checkbox"/> Dressing        | <input type="checkbox"/> Personal Hygiene                          |
| <input type="checkbox"/> Gardening       | <input type="checkbox"/> Other: _____                              |

Are you currently having Physical Therapy anywhere?  Yes  No

Do you have pain or weakness in your: (please check all that apply):

- |                               |  |
|-------------------------------|--|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Upper Extremities (Shoulders, Wrists)             |
| <input type="checkbox"/> Back | <input type="checkbox"/> Lower Extremities (Hips/Legs, Knees, Ankles/Feet) |

Are you currently getting Home Health Services? Does a nurse come to your house?  Yes  No

Current Living Environment:

Do you live:  Alone;  With Spouse;  With Family Member;  With Friend

Living in a  single level home;  double or-tri-level home;  Apartment;  Assisted Living

Do you have stairs in your home;  yes (how many) \_\_\_\_\_  No

Who does the cooking, cleaning, laundry and shopping in your home: \_\_\_\_\_

Do you use Oxygen?  Yes  No Name of Oxygen Provider: \_\_\_\_\_

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Most of the time |
| <input type="checkbox"/> At home only | <input type="checkbox"/> At night only    |

Have you been hospitalized in the past year?  No  Yes

(If yes, please describe including approximated dates, reason for hospitalization)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you now taking any medications including non-prescription medication? Please list below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

(please continue on page 2)



Medical History form page 2

Do you have, or have you had, any of the following diseases or problems?

- |                   |                              |                             |                     |                              |                             |
|-------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|
| Diabetes          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hypertension        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immune System       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bowell            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental Illness      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Renal Disease       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nervousness       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anxiety             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easily Frustrated | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizures            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of Spouse    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drug Abuse        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loss of Socializing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| GI Disturbances   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Urinary Problems    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing Problems  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Visual Problems     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Disease     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Unsteady on feet    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please describe any "yes" answers to the above questions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any disease or problem not listed above that we should know about? Please explain...

What kinds of goals or activities would you like to be able to do after completing therapy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PSYCHOSOCIAL SERVICES:

\_\_\_\_\_ offers psychosocial services. Would you like to be seen by our Licensed Clinical Social Worker (LCSW) for an evaluation?

Yes If YES, please write reason for evaluation: \_\_\_\_\_

No If NO, please sign below:

I am aware of an LCSW on staff and psychosocial services at \_\_\_\_\_. At this point I do not require a psychosocial evaluation.

***Patient's Signature (or individual completing this form for patient)***

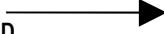
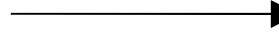
**I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE EVALUATION PROCESS WILL BE ANSWERD TO MY SATISFACTION. I WILL NOT HOLD THE PROGRAM OR ANY OF ITS STAFF RESPONSIBLE FOR ANY ERROR OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THE FORM.**

\_\_\_\_\_  
***Patient's Signature (or individual completing this form for patient)***

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_

RESPIRATORY THERAPY CLINICAL OUTCOMES~~INITIAL VISIT~~

<b>EDUCATION~~Rate yourself on how well ~ you understand the below materials~</b>	<b>I DO UNDERSTAND</b> 			<b>I DON'T UNDERSTAND</b>	
	1	2	3	4	5
Anatomy & Physiology of Lungs	1	2	3	4	5
Benefits of Exercise	1	2	3	4	5
Controlled Cough	1	2	3	4	5
Controlling Stress	1	2	3	4	5
Depression Management	1	2	3	4	5
Diaphragmatic Breathing	1	2	3	4	5
Disease Process	1	2	3	4	5
Energy Conservation Techniques	1	2	3	4	5
Environmental Issues/Triggers causing Shortness of breath	1	2	3	4	5
Home Exercise	1	2	3	4	5
Infection Control	1	2	3	4	5
Medication Administration/effects/Side effects	1	2	3	4	5
Oxygen Therapy & Use	1	2	3	4	5
Pursed Lip Breathing	1	2	3	4	5
Relaxation Exercises	1	2	3	4	5
Secretions	1	2	3	4	5
Spirometry/PFT Results	1	2	3	4	5
Travel	1	2	3	4	5
Recovering From Severe shortness of breath	1	2	3	4	5
<b>LEVEL OF DIFFICULTY</b>	<b>Easy</b> 			<b>Hard</b>	
Eating	1	2	3	4	5
Simple personal care (washing face, combing hair)	1	2	3	4	5
Taking full bath or shower	1	2	3	4	5
Dressing	1	2	3	4	5
Picking up or Straightening up	1	2	3	4	5
Sweeping or Vacuuming	1	2	3	4	5
Shopping	1	2	3	4	5
Cooking or doing dishes	1	2	3	4	5
Laundry	1	2	3	4	5
Walking around your house	1	2	3	4	5
Walking your pace on level surfaces	1	2	3	4	5
Walking one block	1	2	3	4	5
Walking with others your age	1	2	3	4	5
Walking up a slight hill	1	2	3	4	5
Walking up stairs	1	2	3	4	5

Patient Name: \_\_\_\_\_