Valley CORF
Sign In sheet

Patient's Name: _____

Today's Date	Signature	Time Check In	Comments

Valley CORF
Medical History

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Do you get SHORT OF BREATH? ☐ - Yes ☐ - No

Do you have joint or muscle PAIN or STIFFNESS? ☐ - Yes ☐ - No If yes:_____

Activities that cause the shortness of breath or other difficulties:

☐ - Walking ☐ - Climbing Stairs ☐ - Exercising ☐ - Lying Down
☐ - Carrying, lifting, pulling, pushing ☐ - Reaching up and/or down ☐ - Talking

☐ - Self Care Daily activities (self-feeding/ eating; personal hygiene/ grooming, dressing, bathing, toileting)
☐ - Home & Community Daily activities (housekeeping, cooking, shopping, taking care of others/pets, volunteer/work activities)
☐ - Participating in Social or Recreational activities

☐ - Other: specify_____

Do you perform all daily activities: ☐ **INDEPENDENTLY** or you need ☐ **ASSISTANCE from** partner/caregiver/family/hired helpers

VERY IMPORTANT – (avoids billing complications)

Are you receiving HOME HEALTH CARE ? (ie if a nurse, therapist comes to your house for any type of home health care services) Yes___ No____

Current Living Environment:

Do you live: ☐ - Alone ☐ - with Spouse ☐ - with Family Member ☐ - with Friend/Roommate
Do you live in a: ☐ - Single level home ☐ - Double level home ☐ - Tri-level home ☐ - Apartment ☐ - Assisted Living
Do you have a caregiver? ☐ - No ☐ - Yes if Yes: ☐ - part-time ☐ - 24/7

Do you have stairs in your home? ☐ -Yes ☐ - No
If Yes, how many stairs/steps inside?_____How many stairs/steps for outside access?_____ ☐ Elevator available

Memory: ☐ Good ☐ Fair ☐ Poor **Dizziness?** ☐ NO ☐ YES ☐ occasionally

Does your current breathing problem affect your mood? ☐ - Yes ☐ - No

Pacemaker / Internal Ports? ☐ - Yes ☐ - No Precautions/Medical restrictions? _____

Cough: ☐ - NONE ☐ - OCCASIONAL ☐ - FREQUENT ☐ - DRY COUGH
☐ - PRODUCTIVE COUGH with secretion: ☐ -THIN ☐ - THICK ☐ - CLEAR ☐ - WHITE ☐ - YELLOW ☐ - GREEN ☐ - BROWN

Smoking History: ☐ - Yes ☐ - No
If yes, when did you quit?_____ How many packs a day?_____

Do you use Oxygen? ☐ - Yes ☐ - No Liter:_____Name of Oxygen Provider:_____
☐ - All the time ☐ - As needed
☐ - At home only ☐ - At night only

Have you been hospitalized in the past year? ☐ - No ☐ - Yes
(If yes, please describe including approximated dates, location and reason for hospitalization)

_____

_____

Please list you personal goal(s) or activities you would like to be able to do after completing therapy:

_____

_____

Please list the medications currently taken, dosage and how many times per day you take them :

_____ _____
_____ _____
_____ _____
_____ _____
_____

Please check all that applies to the best of your knowledge

Prior *or* current occupation (s) : (*even if retired*)_____

Prior to current injury or illness: ☐ retired ☐ worked ☐ on disability

Numbness/Tingling/Burning? ☐ NO ☐ YES: Hands/arms: ☐ Right ☐ Left Feet/legs: ☐ Right ☐ Left

Hand tremors? ☐ NO ☐ YES: ☐ Right ☐ Left

Do you HAVE or USE assistive devices/ adaptive equipment?:

☐ cane ☐ walker with seat ☐ folding front wheel walker ☐ manual wheelchair ☐ electric wheelchair/scooter
☐ shower chair/bench ☐ safety grab bars in the shower/bathtub area ☐ hand held shower hose ☐ no-slip bath mat/strips
☐ high toilet seat ☐ toilet commode ☐ portable urinal
☐ long handle bath sponge ☐ long handle shoehorn ☐ Sock Aid/donner ☐ elastic shoelaces
☐ reacher/grabber ☐ dressing stick ☐ button hook ☐ special eating utensils

As of TODAY do you have difficulty, aggravating pain, weakness, fatigue or shortness of breath with or during:

Activities of Daily Living	**no difficulty**	**minimal difficulty**	**moderate difficulty**	**quite a bit of difficulty**	**extreme difficulty & unable to do**	not doing it
Self Feeding / Eating: *cutting/serving food; holding utensils, cup; bringing food to mouth, swallowing*	☐	☐	☐	☐	☐	☐
Personal Hygiene: *oral hygiene, washing face/hands, deodorant/lotion application, hair combing/brushing, cleaning ears*	☐	☐	☐	☐	☐	☐
Grooming: *shaving, nail care, hair styling, make-up, skin care, etc.*	☐	☐	☐	☐	☐	☐
Toileting/Toilet hygiene: *able to reach for cleaning, lift up underwear*	☐	☐	☐	☐	☐	☐
Upper body dressing: *teeshirt, blouse, shirt, dress, robe, jacket, sweater, underwear, tie, etc.*	☐	☐	☐	☐	☐	☐
Lower body dressing: *pants, skirts, underwear, socks/stocking, shoes*	☐	☐	☐	☐	☐	☐
Fasteners: *open/close buttons, zippers, buckles, snaps, Velcro closures; shoelaces*	☐	☐	☐	☐	☐	☐
Bathing / Showering: *washing & drying body and hair*	☐	☐	☐	☐	☐	☐
Care for Others: *family members, children*	☐	☐	☐	☐	☐	☐
Care for Pets: *type:*_____	☐	☐	☐	☐	☐	☐
Home Management: *house cleaning, making bed, taking garbage out, laundry, gardening*	☐	☐	☐	☐	☐	☐
Meal Preparation & Clean up: *cooking, washing dishes/countertops, opening jars, peeling, cutting; lifting pots/pans*	☐	☐	☐	☐	☐	☐
Shopping: *prolonged walking, lifting shopping bags/items, pushing shopping cart, reaching up/down shelves; choosing, trying on, paying*	☐	☐	☐	☐	☐	☐
WORK / Job Performance: *describe*_____	☐	☐	☐	☐	☐	☐
Volunteer Participation: *describe*_____	☐	☐	☐	☐	☐	☐
SOCIAL / Recreational Activities: *describe*_____	☐	☐	☐	☐	☐	☐

Any activities that you gave up because of current condition or injury?_____

_____

Please check off all that apply

Pulmonary/lungs
- ☐ COPD
- ☐ Obstructive sleep apnea
- ☐ Frequent bronchitis
- ☐ Emphysema
- ☐ Frequent pneumonia
- ☐ Asthma
- ☐ Pulmonary embolism
- ☐ Tuberculosis
- ☐ ILD/Pulmonary Fibrosis
- ☐ Bronchiectasis
- ☐ Pulmonary Hypertension
- ☐ Pulmonary Edema
- ☐ Sarcoidosis

Cardiovascular
- ☐ History of angina or heart attack
- ☐ Hypertension
- ☐ History of arrhythmia
- ☐ History of poor circulation/DVT
- ☐ Rheumatic fever
- ☐ Congestive Heart Failure
- ☐ Heart valve disease
- ☐ Blood clots

Muscle/joint/bone
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Rheumatoid arthritis
- ☐ Joint Replacement (where/when)_____ _____
- ☐ History of falls (how many)_____ latest fall:_____
- ☐ Fractured/broken bones (specify) _____ _____
- ☐ Torn tendons/muscles (specify) _____ _____
- ☐ Fibromyalgia
- ☐ Osteopenia
- ☐ Neck/Back/Shoulders/Hand pain
- ☐ Hip/Knees/Ankles pain (right, left or both)
- ☐ Carpal Tunnel Syndrome (right, left or both)

Neurological/Psychiatric
- ☐ History of stroke
- ☐ TIA
- ☐ Seizures/Epilepsy
- ☐ Parkinson's Disease
- ☐ Dementia or Alzheimer's Disease
- ☐ Memory Loss
- ☐ Depression/Anxiety
- ☐ Panic Attacks
- ☐ History of Traumatic Brain Injury /head concussion
- ☐ Vertigo
- ☐ Migraines
- ☐ Insomnia
- ☐ Peripheral Nerve Disease
- ☐ Neuropathy

General
- ☐ Weight gain/loss of 10+lbs. during last 6 months
- ☐ Cancer/Tumor: specify_____
- ☐ Possible pregnancy (women)

Eyes, ears, nose, throat
- ☐ Blurred vision
- ☐ History of glaucoma or cataracts
- ☐ Glasses/contacts: __ daily __ reading only __ driving only
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Hearing Aids: __Right ___Left
- ☐ Sinus problems
- ☐ Allergies
- ☐ Frequent ear infections

Genitourinary
- ☐ Frequent or painful urination
- ☐ Bladder infections
- ☐ HIV infection

Skin/Breast
- ☐ Itching/Psoriasis
- ☐ Easy bruising
- ☐ Change in moles
- ☐ Abnormal mammogram
- ☐ Rashes
- ☐ Hives

Lymphatic/Hematologic/Metabolic
- ☐ Diabetes Mellitus
- ☐ Hyper/Hypo-thyroid
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Anemia
- ☐ Blood transfusion (if yes, when:_____)

Gastrointestinal
- ☐ Poor appetite
- ☐ Nausea or vomiting
- ☐ Abdominal pain
- ☐ Kidney failure/Chronic Kidney disease
- ☐ Hemodialysis
- ☐ Trouble swallowing
- ☐ Diarrhea/Constipation
- ☐ Hemorrhoids
- ☐ Stomach Ulcers
- ☐ Rectal bleeding or blood in stools
- ☐ Liver failure
- ☐ Diverticulitis
- ☐ Crohn's disease
- ☐ Colon polyps
- ☐ Prostate Disease

PSYCHOSOCIAL SERVICES

Valley CORF Inc. offers psychosocial services.
If you would like more information as to these services, please request the **"Social Service Assessment"**

Would you like to be seen by our Licensed Clinical Social Worker (LCSW) for an evaluation?

☐ - **Yes** ☐ - **No**

If Yes. Please list a reason: _____

If you selected No, Please sign and date this section:

*I AM AWARE OF AN LCSW ON STAFF AND PSYCHOSOCIAL SERVICES AT VALLEY CORF. AT THIS POINT, I CHOOSE **NOT** TO HAVE A PSYCHOSOCIAL EVALUATION*

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

MEDICAL HISTORY VERIFICATION

Please sign and date this Section:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE EVALUATION PROCESS WILL BE ANSWERED 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**

Explanation to patient/family/caregiver about the services they are about to receive – its purpose and expectations. Yes____ No___

If no, was corrective action taken ? Yes____ No___

Valley Corf

Covid 19 Questionnaire

Name of Patient: _____

1. Have you experienced any of these symptoms in the last 14 days:
   a) Fever yes no
   b) Cough , sore throat yes no
   c) Unusual shortness of breath yes no
   d) Nausea yes no
   e) Unusual Fatigue yes no
   f) Chest tightness yes no
   g) Weakness yes no
2. Have you travelled in the last 14 days? Yes___ No____
   If yes, please list where have you been? _____
3. Have you been in contact with a positive tested covaid10 recently?

   If yes, please state date _____
4. Are you vaccinated? How many shots? _____ Please show your card to the front office for verification

Additional comments:

_____

_____

VALLEY CORF – PATIENT REGISTRATION Rev 5/25/22

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** **Email Address**	**Patient's Social Security#**
Person financially responsible for this account **Self** ☐ **Spouse** ☐		**Responsible Party's Birth Date**	**Responsible Party's Social Security#**
Person to contact in case of emergency:	**Phone number**	**Relationship to patient**	
ARE YOU CURRENTLY EMPLOYEED Y ☐ N ☐ If no proceed to next section	**Occupation**	**Retired? Month/Year**	**How long at the current employer?**
Name of Employer Address			**Business Phone Number**
Referred by: (include address and phone number)			

INSURANCE INFORMATION (no need if insurance card is provided)

Medicare YES ☐ NO ☐	**Medicare Number:**		**Effective Date**
Primary Insurance Name/Number	**Address**	**Policy#** **Group#**	**Effective Date**
Secondary Insurance Name/Number	**Address**	**Policy#** **Group#**	**Effective Date**

Assignment of Benefits / Information Release / Authorization to Treat:

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

Rev 4/1/19

Valley CORF

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 health care 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:

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

Patient Name: _____ Signature_____ Date_____