LIBERTY HOSPITAL

Rehabilitation Therapy

REHABILITATION THERAPY PATIENT AGREEMENT

Welcome to Liberty Hospital Rehabilitation Therapy. We are pleased that you have selected us as your provider of therapy. In order to best serve you, we ask that you take a moment to review and sign the following agreement. It explains our attendance and appointment cancellation policies. If you have any questions, we will be glad to answer them.

PUNCTUALITY

It is important that you arrive on time for your scheduled therapy session. Your treatment times have been planned out so as to offer you optimal quality time with your therapist. Should you find that you are running late for an appointment, your appointment will end at the scheduled time so the treatment of other patients will not be negatively effected. If you are more than 15 minutes late for your appointment, we may cancel that day's treatment and reschedule you for another date and/or time.

APPOINTMENT CANCELLATION POLICY

In an effort to keep our patients and staff as safe as possible, we encourage you to re-schedule your appointment if you have any signs or symptoms of illness.

We ask that you provide us at least 24 hours' notice for appointment cancellation or rescheduling of appointments. If you should have any combination of three appointment cancellations with inadequate notice and/or "no shows" for scheduled appointments, we reserve the right to cancel any remaining appointments, notify your physician and discharge you as a patient.

You may reach us by voicemail at your convenience during non-working hours, weekends and holidays.

PERSONAL BELONGINGS

Lockers may be available for you to store personal belongings. Please keep key to locker in your possession at all times. Liberty Hospital will not be responsible for items that are lost or stolen.

CHILDREN

If children must accompany you to therapy, please make sure that they remain with you for the duration of therapy. Children are not allowed unsupervised in our gym area. Please note that the presence of children may impact the focus of care for you and for other therapy clients.

Patient Signature	Date	Time
Witness Signature	Date	Time

*DT05
52*

Liberty Hospital
Liberty, MO 64068

Label

Have you ever had or been treated for:	
Frequent headaches	☐ Yes
Neck injury/ Whiplash Other:	☐ Yes
Recurrent neck pain	☐ Yes
Pain radiating into: *O arms, O hands, O buttocks, O legs*	☐ Yes
Numbness/tingling in: *O arms O hands, O buttocks, O legs*	☐ Yes
Neuropathy	☐ Yes
Diabetes: Type 1 or Type 2	☐ Yes
Lung problems, including- (please circle) *Asthma / Tuberculosis / Shortness of breath/ Emphysema/ COPD/ PE*	☐ Yes
Double Vision / visual problems	☐ Yes
Epilepsy / seizures	☐ Yes
Stroke or Brain Injury	☐ Yes
Dizziness / Vertigo/ Black outs	☐ Yes
Chest pains	☐ Yes
Heart Conditions: (please circle) *Pacemaker/ Coronary Artery Disease/ Coronary Artery Bypass/ Heart Attack/ Stents*	☐ Yes
High blood pressure	☐ Yes
Anemia / leukemia	☐ Yes
Cancer or Tumors ☐ Type:	☐ Yes
Back problems: Please list ☐ Bulging / herniated discs ☐ spinal cord stimulator ☐	☐ Yes
Carpal tunnel syndrome	☐ Yes
Arthritis: ☐OA ☐RA	☐ Yes
Recurrent joint pains: (please circle) *hand wrist elbow Shoulder hip knee ankle feet*	☐ Yes
Fracture of: (please circle) *hand wrist elbow Shoulder hip knee ankle feet* ☐ *other:*	☐ Yes
MS	☐ Yes
Parkinson's Disease	☐ Yes
Abdominal pain	☐ Yes
Hepatitis / liver/ kidney disease	☐ Yes
Tendonitis / bursitis	☐ Yes
Psychiatric Disorders: ☐ Bi-polar ☐ Depression ☐Other _____	☐ Yes
Osteoporosis	☐ Yes
Alzheimer's/ Dementia	☐ Yes

Do you have an Advance Directive (e.g. living will, durable power of attorney, or any other written instructions regarding your health care treatment decisions? ☐ Yes ☐ No
If ***Yes***, is it current?
☐ Yes. Where? ☐ In your possession ☐ On file with Liberty Hospital ☐ Other:
☐ No. Would you like for Liberty Hospital's Social Services Department to perform a consultation over the telephone? ☐ Yes ☐ No

Describe the problem for which you seek therapy: _____

_____

When did these problems begin? _____

Have you had this problem before? _____

If yes, what did you do for the problem(s)? _____

Did the problem(s) get better? ☐ Yes ☐ No; How long did the problems last? _____

How are you taking care of the problem(s) now? _____

_____

Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No, if yes:

Describe the exercise: _____

On average, how many days per week do you exercise or do physical activity? _____

For how many minutes, on an average day? _____

Do you use (a): ☐ Cane ☐ Walker ☐ Manual wheelchair ☐ Motorized wheelchair
☐ Glasses, hearing aids ☐ Other: _____

With whom do you live? ☐ Alone ☐ Spouse only ☐ Spouse and other(s)
☐ Child ☐ Personal care attendant ☐ Other relative(s) (not spouse or children)

☐ Group setting ☐ Other: _____

Where do you live? ☐ Private home ☐ Private apartment
☐ Assisted living / group care ☐ Long-term care facility/nursing home ☐ Other: _____

Does your home have: ☐ Stair with no railing ☐ Stairs with a railing ☐ Ramps ☐ Elevator

Please check if applicable: ☐ I am currently pregnant.

☐ I have recently received home health services provided by _____

Dysarthria	☐ Yes	Frequent falls	☐ Yes		
Dysphagia	☐ Yes	MRSA	☐ Yes		
Memory Problems	☐ Yes	Bladder/Bowel control	☐ Yes		
Voice problems	☐ Yes	DVT(blood clot)	☐ Yes		
Tuberculosis	☐ Yes	Other_____	☐ Yes		

*DT009

Please list the following: ☐See list

Previous surgeries and the date	Current **prescribed** and **non-prescribed** medication	**Allergies** Are you allergic to latex/rubber? ☐ Yes ☐ No

Employment/Work Occupation: _____

☐ Working full time ☐ Working part time ☐ Homemaker ☐ Retired ☐ Student ☐ Unemployed

If currently off work due to injury, what is your anticipated date of return? _____

Education: Please check the highest level of education completed.

☐Elementary ☐High School ☐Some college/ tech school ☐College ☐Graduate School/Advanced degree

Social Habits: Do you currently smoke? ☐ Yes ☐ No If yes: How many packs per day? _____

In the past year, have you had any of the following? Please circle all that apply.

Bone scan CT scan MRI X-ray EEG, EKG, EMG Myelogram Stress Test

Were any of these tests performed at Liberty Hospital? ☐ Yes ☐ No

Are you currently seeing, or have you recently seen anyone else for this problem?

☐ Acupuncturist	☐ Cardiologist	☐ Chiropractor
☐ Home health	☐ Massage Therapist	☐ Neurologist
☐ Orthopedist	☐ Osteopath	☐ Podiatrist

Patient Signature	Date	Time
Therapist Signature	Date	Time
Therapist Signature	Date	Time

Reviewed/Updated	Date/Time