Frederick Health

Welcome to Frederick Health Physical Therapy & Sports Rehab, offering Physical Therapy, Occupational Therapy, Speech Therapy, Pelvic Health Therapy, Lymphedema & Aquatic Therapy for both adults and pediatrics. Through evaluation and individualized treatment planning, our therapists will help you reach your rehabilitation goals and achieve your full potential. **You are the most important member of the treatment team!**

- To achieve the maximum benefits from your program, you must be an active participant in your program, and we ask that you attend all scheduled sessions.
- For ease of your treatment, please bring or wear loose comfortable clothing, bathing suit, eye glasses, and/or hearing aids.
- Please make every effort to be on time for your appointment. Your therapist may need to shorten your visit if you are late to avoid inconveniencing patients who follow. If you are more than 15 minutes late, we reserve the right to reschedule your appointment.
- Please call our office when you must cancel a scheduled appointment. **Failure to cancel a scheduled appointment** will be considered a **no show. PLEASE NOTIFY US 24 HOURS IN ADVANCE IF YOU CAN NOT MAKE YOUR APPOINTMENT. After three (3) no shows or cancellations, you may be discharged and your doctor will be notified.** If this occurs, you will need to return to your doctor for a new prescription to resume therapy.
- If you suspect that you may have or have been diagnosed with a communicable/infectious disease such as shingles, pink eye, strep throat, frequent or infectious diarrhea (sometimes called "C diff"), call the clinic prior to your appointment to discuss the appropriateness of your attendance with your therapist.
- Our staff makes every effort to make your treatment here a positive experience. To better assist you with the coordination of therapy as ordered by your physician, **we encourage you to know your outpatient therapy benefits.** Please take the time to review your benefit handbook or contact member services located on your member ID card.
- It is your responsibility to notify us of any changes in your insurance policy. Failure to provide accurate/updated information may result in denial of coverage and you will assume financial responsibility.
- Please have family members and friends, unless a part of therapy, wait in the lobby. An adult **must** accompany children under 10 who are waiting in the lobby.
- **Co-payments are due at the time service is rendered and can be made at the registration desk.**

I Expect From My Therapist:

- _____
- _____
- _____

*Our Goal Is To Provide Excellent Service To **You***

Your feedback is very important in determining the effectiveness of your treatment. If you have questions, concerns or complaints, please discuss them with your therapist so adjustments can be made. We look forward to working with you.

_____ _____

Patient signature **Date** **Frederick Health Witness signature** **Date**

Frederick Health

What Brought You To Frederick Health Physical Therapy & Sports Rehab?

□ A family member or friend told me about Frederick Health Physical Therapy & Sports Rehab

□ I saw a flyer for Frederick Health Physical Therapy & Sports Rehab Services

□ I read a Frederick Health Physical Therapy & Sports Rehab article in *Frederick's Child* Magazine

□ I saw Frederick Health Physical Therapy & Sports Rehab information at Health Unlimited Family Fitness

□ I heard about Frederick Health Physical Therapy & Sports Rehab on the radio

□ I attended a Frederick Health Physical Therapy & Sports Rehab seminar/event

□ I found you online:

- □ Frederick Health Website
- □ Google Search
- □ Frederick Health Social Media

□ My Insurance recommended Frederick Health Physical Therapy & Sports Rehab

□ I was a previous patient

□ My Physician referred me

Physician Name_____

□ Another source? Please let us know!

Thank you!

Frederick Health

PATIENT MEDICAL HISTORY

Name: _____ **Date:** _____

Diagnostic Studies:

MRI: Area _____ Date _____
X-rays: Area _____ Date _____
CT Scan: Area _____ Date _____
Ultrasound: Area _____ Date _____
EMG: Area _____ Date _____
Nerve Conduction: _____ Date _____

Myelogram: Area _____ Date _____
Nuclear Medicine: Area _____ Date _____
Urinalysis: Test _____ Date _____
Biopsy: Test _____ Date _____
Mammogram: Test _____ Date _____
Barium Swallow: Test _____ Date _____

Have you had Surgery for this Injury?

Area _____ Date _____ Area _____ Date _____
Area _____ Date _____ Area _____ Date _____
Area _____ Date _____ Area _____ Date _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

Orthopedist Date _____
Neurologist Date _____
Neurosurgeon Date _____
Emergency Room Date _____
Obstetrician Date _____
Dentist Date _____
Oral Surgeon Date _____

Physical Therapy Date _____
Occupational Therapy Date _____
Speech Therapy Date _____
Massage Therapy Date _____
Chiropractor Date _____
Cardiologist Date _____
Other Date _____

Please check all that apply, do you now have or have you ever had any of the following?

General Good Health _____
Hypertension _____
Osteoarthritis _____
Osteoporosis _____
Osteopenia _____
Glasses/Contacts _____
Shortness of Breath _____
Voice Changes _____
Abdominal Pain _____
Hearing Loss _____
Heart Disease _____
Diabetes _____

Asthma _____
Bronchitis _____
Stroke _____
Emphysema _____
Seizures _____
Pregnant _____
Bruise Easily _____
Nausea _____
Fevers _____
Sore Throat _____
Pacemaker _____

Angina _____
Fatigue _____
Headaches _____
Depression _____
Cancer _____
Weakness _____
Epilepsy _____
Coughing _____
Tuberculosis _____
Dizziness _____
COPD _____

Do you Smoke? Yes___ No___ Packs/Day _____

Patient/Guardian Signature: _____ Date _____

Clinician Signature: _____ Date _____

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for taking	Date Started	Prescriber

Patient Signature_____ Date:_____