

Thank you for choosing Therapy Works to assist you with your current condition.

Please fill out the enclosed paperwork and bring back with you to your appointment.

Important things to remember:

- You will need to bring your **insurance card, a photo ID** and the referral/prescription from the referring physician.
- Payment of any co-pay associated with your insurance is expected at time of service and at each visit. If you have questions regarding co-pays, or any deductible, please contact your insurance company for detailed information
- Wear comfortable clothing.

NOTE: If your visit is due to an accident or workman compensation, please have the **Claim #** and the **name of the company this claim is through.**

Therapy Works is located at 2004 N. 12th Street across from Community Hospital.

If you have any questions, please call (970) 256-6378 to speak with one of our staff members

Sincerely,

Therapy Works Staff

Scheduling Communication Preference

Please Print

PATIENT NAME: _____ DATE OF BIRTH: _____

In an effort to guard your privacy while allowing for efficient scheduling, please answer the following questions on how best to contact you regarding scheduling issues.

- No, it ***is NOT*** ok to leave messages or voicemails.
- Yes, it is ok to leave messages or voicemails.

Please write all of YOUR contact numbers where we may leave a message:

- Home Phone: _____
 - Work Phone: _____
 - Cell Phone: _____
- (_____)_____ (_____)_____ (_____)_____

Persons authorized to receive messages/information at the above numbers:

_____		_____	
Name	Relationship	Name	Relationship

Only the above people will be able to confirm or change your appointment.

Please note: **ANY PERSON** (including family members) requesting **ANY** information, including appointment confirmations and changes, **MUST** provide us with 3 points of information about you including: 1. Name, 2. Date of Birth, 3. Zip Code.

Thank you for assisting us.

I authorize Community Hospital Therapy Works to leave protected health information inquiries that may include the following: Name of patient, Name and phone number of the clinic; Name of treating therapist(s), Appointment times and dates; and Scheduling information/requests.

Signature: _____ Date: _____

Relationship, if not patient: _____

Cancellation/No Show/Co-Pay Policies

Thank you for choosing Community Hospital Therapy Works for your therapy services. Due to the volume of new patients and limited appointments, we require that you notify our office **24 hours in advance** if you are unable to keep your appointment. We do understand that emergencies arise. In such cases, please contact us as soon as possible to cancel or reschedule your appointment.

Failure to call and cancel an appointment is considered a "No Show." After two (2) such occurrences, any additional scheduled appointments will automatically be cancelled. Your therapist will consider you a discharged patient, and will send a note to your physician indicating non-attendance. You will have to contact your therapist to discuss continuation of therapy.

Along with quality treatment, it is the goal of this clinic to treat patients at their scheduled time. If you are more than fifteen (15) minutes late for your appointment, your appointment may need to be rescheduled.

Co-pays are collected prior to each treatment. Failure to pay may result in a bill from the health system's billing department.

We want to meet the goals of all of our patients, and we appreciate your assistance. Thank you for your help! Please let us know if there is something more we can do for you.

To cancel or reschedule appointment, please call (970) 256-6378.

Terri Brown,
Director, Therapy Works
Community Hospital

I acknowledge that I have read and understand these policies.

Patient Signature

Date

Community Hospital Therapy Works Health Assessment Intake Form

To ensure that you receive a complete and thorough evaluation, please provide us with your important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank You!!

NAME: _____ DATE OF EVALUATION: _____

OCCUPATION: _____ LEISURE ACTIVITIES: _____

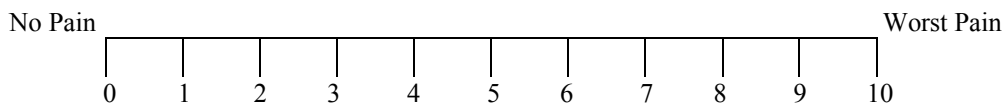
TELL US ABOUT YOUR CONDITION

Why have you been referred to therapy? _____

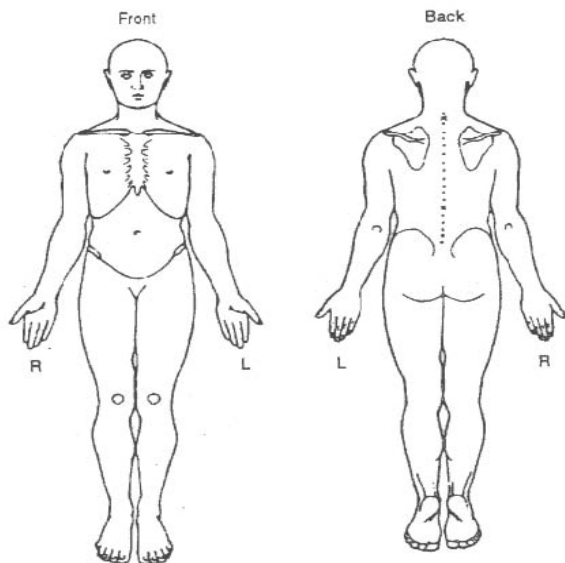
How and When did your condition occur? _____

What limitations have resulted from your condition? _____

Please indicate your current pain level by putting an (x) on the line below.



Indicate on body diagrams where your symptoms are located



Please check any word that describes your pain.

- | | |
|---|--|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Dull/Aching |
| <input type="checkbox"/> Sharp/Shooting | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Burning | |

Check all that apply ...I currently have difficulty:

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Driving | <input type="checkbox"/> Getting up from a chair |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Bending at the waist |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting |

What makes your pain better? _____

What makes your pain worse? _____

Is your pain: constant OR does it come and go?

Please check (✓) any of the following whose care you are under:

- | | | |
|--|---|---|
| <input type="checkbox"/> Medical Doctor (DO or MD) | <input type="checkbox"/> Psychiatrist/Psychologist/Counseling | <input type="checkbox"/> Physical, Occupational, Speech Therapy |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Dentist | <input type="checkbox"/> Other _____ |

Date of last physical examination: _____ By Whom? _____

If you have seen any of the above during the past three months, please describe the reasons (illness, medical condition, physical, etc)?

Have you had any of the following diagnostic tests done for your current condition? If yes, please indicate approximate dates.

X-ray _____ MRI _____ CT scan _____ Ultrasound _____ Other _____

Have you experienced changes in how you feel recently?

- During the past month, have you noticed a general change in your medical status? YES NO
During the past month, have you been feeling down, depressed, or hopeless? YES NO
During the past month, have you been bothered by having little interest or pleasure in doing things? YES NO

In the past 3 months, have you noted (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Weight Loss / Gain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Dizziness / Light-headedness | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fatigue - Unusual | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Regular Cough |
| <input type="checkbox"/> Fever / Chills / Sweats | <input type="checkbox"/> Heart Racing in your Chest |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Tremors or Seizures | <input type="checkbox"/> Heartburn / Indigestion |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Paleness |
| <input type="checkbox"/> Vision Changes / Eye Redness | <input type="checkbox"/> Constipation / Diarrhea |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Blood in Stools |
| <input type="checkbox"/> Problems Sleeping | <input type="checkbox"/> Post-Menopause |
| <input type="checkbox"/> Sexual Difficulties | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Pregnant (or think you might be) |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Stress at Home or Work |

FAMILY MEDICAL HISTORY INFORMATION: Please check (✓) if anyone in your immediate family (parents, brothers, sisters) has ever been treated for the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Inflammatory Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression |

Social History

How many caffeinated coffee or beverages do you drink per day? _____

Tobacco use: How many packs do you smoke per day? _____ For how many years? _____ If quit, when? _____

How many days per week do you drink alcohol? _____ How much do you drink at an average sitting? _____

Living environment

Does your home have:

- Stairs – with or without rails? Ramp? Uneven terrain? Adaptive equipment? Walk in shower / tub?
 Any obstacles? Explain: _____

Do you use an assistive device? Walker – with or without wheels Cane Crutches Wheelchair
 Orthosis/Prosthesis Other _____

Do you live alone? Yes No Are you able to drive? Yes No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

How can we help you?

Your input regarding the decisions of your therapy treatment and healthcare are important to us!!

What would you like to accomplish through therapy? What should we work on? Please list your goals below:

- 1.
- 2.
- 3.

Understanding your condition is important!

As part of your evaluation and treatment here at Therapy Works, our therapists strive to educate you on your current condition, as well as to provide recommendations for treating that condition. We recognize that people have different ways of learning. Please help us to understand how we can provide the greatest learning experience for you regarding your current condition and our treatment recommendations.

How do you learn Best? (check all that apply)

- Seeing
- Hearing
- Doing

Do you need a translator to assist you during future visits? YES NO

If YES, please indicate language: _____

Thank you for choosing Therapy Works to help you with your current condition.

Medical History Profile

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? YES NO List other allergies we should know about: _____

HAVE YOU DECLARED THE ADVANCED CLINICAL DIRECTIVE OF DO NOT RESUSCITATE? YES NO

Please check (√) if you have EVER been diagnosed as having any of the following conditions:

		Date of Onset	*** For Therapist Use *** Comments
<input type="checkbox"/> Cancer	If YES, what kind _____		
<input type="checkbox"/> Heart Problems	If YES, what kind _____		
<input type="checkbox"/> High Blood Pressure			
<input type="checkbox"/> Circulation Problems			
<input type="checkbox"/> Asthma			
<input type="checkbox"/> Stomach Ulcers			
<input type="checkbox"/> Chemical Dependency	(i.e. alcoholism, drugs)		
<input type="checkbox"/> Thyroid Problems			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Multiple Sclerosis			
<input type="checkbox"/> Rheumatoid Arthritis			
<input type="checkbox"/> Other arthritic conditions			
<input type="checkbox"/> Depression			
<input type="checkbox"/> Hepatitis	Type: A B C		
<input type="checkbox"/> Tuberculosis			
<input type="checkbox"/> Stroke			
<input type="checkbox"/> Kidney Disease	If YES, what kind _____		
<input type="checkbox"/> Blood Clots			
<input type="checkbox"/> Osteoporosis			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Other _____			

Please describe any significant injuries for which you have been treated (including fracture, dislocation, sprains) and the approximate date of injury.

DATE	INJURY

DATE	INJURY

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	SURGERY/HOSPITALIZATION & REASON

DATE	SURGERY/HOSPITALIZATION & REASON

