John T. Mather Memorial Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

PS3550

Patient Name:_____ Date of Birth:_____ Phone: _____
Referring Physician:_____ Reason for Treatment: _____
Other Conditions:_____

Do you have a Health Care Proxy?
☐Yes If Yes Copy Requested Name: _____ Phone Number: _____
☐No If No ☐ Documents will be offered on arrival ☐ Documents Declined
Upon arrival did patient bring documents ☐ Yes ☐ No
Current Medications (include over the counter Medications, Herbs and Vitamins): _____

SURGERY/PROCEDURE/XRAYS FOR CURRENT CONDITION	RESULTS IF KNOWN	DATE

ALLERGIES: ☐YES ☐ NO (MEDICINE, FOOD, DRUG, AND LATEX)
REACTION - EXPLAIN _____

MEDICAL HISTORY: (check box if applicable)

- ☐ **STROKES**
- ☐ **AORTIC ANEURYSM**
- ☐ **BLOOD CLOT**
- ☐ **ANEMIA**
- ☐ **HIGH BLOOD PRESSURE**
- ☐ **FRACTURES**
- ☐ **METAL IMPLANT**
- ☐ **SEIZURES**
- ☐ **HEADACHES**
- ☐ **PACEMAKER**
- ☐ **HEART DISEASE/CORONARY BYPASS**
- ☐ **CONGESTIVE HEART FAILURE**
- ☐ **HEART ATTACK**
- ☐ **COPD/EMPHYSEMA/ASTHMA**
- ☐ **BRONCHITIS**
- ☐ **DIABETES**
- ☐ **HYPOGLYCEMIA**
- ☐ **KIDNEY DISEASE/DIALYSIS**
- ☐ **ARTHRITIS/GOUT**
- ☐ **CELLULITIS LOCATION**_____
- ☐ **CROHNS DISEASE**
- ☐ **DIVERTICULITIS/COLITIS**
- ☐ **CANCER TYPE**_____
- ☐ **LYMPH NODE DISSECTION**
- ☐ **CHEMOTHERAPY**
- ☐ **RADIATION LOCATION**_____
- ☐ **OTHER**_____

1. Have you had any recent illness within the last 3 weeks (e.g. colds, influenza, bladder/kidney infection, or cellulitis)
   ☐Yes ☐ No If yes, describe _____
2. Have you noticed any lumps or thickening of skin or muscle anywhere on your body?
   ☐Yes ☐ No If yes, describe _____
3. Do you have any sores that have not healed, or any changes in size, shape or color of wart or mole?
   ☐Yes ☐ No If yes, describe _____
4. Have you had any unexplained weight loss in the last month? ☐Yes ☐ No If yes, how much? _____
5. Do you smoke? ☐ Yes ☐ No If yes, amount daily_____ Number of years_____ Have you quit_____ Date_____
6. How much caffeine do you consume daily, including soft drinks, coffee, tea or chocolate? _____
7. Are you on a special diet prescribed by a physician? ☐ Yes ☐ No If yes, explain _____
8. Have you had any unexplained pain? ☐Yes ☐ No
   If yes, what has been used (include home remedies) _____

OUTPATIENT HISTORY PHYSICAL THERAPY

CURRENT LEVEL OF FITNESS

Please describe any exercises/sport you are currently involved in: _____

_____

When did you start? _____ How often _____

Are there any activities that you cannot do now that you could do before your injury or illness? If yes please describe:

_____

_____

Do you ever experience any shortness of breath or difficulty breathing (e.g. walking, climbing stairs)?

_____

_____

WORK ENVIRONMENT (Does your job involve):

Please check:

- ☐ Prolonged sitting (e.g. desk, computer, driving)
- ☐ Prolonged standing (e.g. equipment, operator, sales, clerk)
- ☐ Prolonged walking (e.g. mill worker, delivery service)
- ☐ Use of large or small equipment (e.g. telephone, forklift, typewriter, drill press, and cash register)
- ☐ Lifting, bending, twisting, climbing, turning
- ☐ Exposure to chemicals or gases

Other, please describe _____

_____

_____

What are your goals or expectations from your Physical Therapy program? _____

_____

_____

_____

Patient Information Completed by: ☐ Patient ☐ Family ☐ Other _____

Signature _____ Date _____

_____ Do not write below this line _____

Therapists Comments: _____

_____

_____

_____

_____

Therapist Signature _____ Date _____

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PS3506

OUTPATIENT REHABILITATION SERVICES
Phone: (631) 476-2737 • Fax: (631) 686-2543

CONTRACT FOR CARE

The following policies have been instituted so that you can receive the maximum benefits from rehabilitation

Attendance - You will receive the greatest benefit from your therapy by being consistent with your prescribed treatment program and by receiving care by your assigned "team" of therapists including Physical Therapist, Physical Therapist Asst., Occupational Therapist, Certified Occupational Therapist Asst. and/or Speech-Language Pathologist. The frequency and duration of your treatment will be decided based on the recommendations of your Physician, Therapy Team, personal schedule and time required to reach reasonable functional goals.

Appointments - We make every attempt to see you at your scheduled appointed time so please notify front desk staff if your wait for your scheduled appointment time is longer than 10 minutes.

Lateness, No Show & Cancellations - As part of your consent for treatment, you agree to notify the office at least 24 hours in advance if you need to cancel an appointment. You can leave a message any time of day or night, if the office is not open. Please call if you know that you will be late for your scheduled appointment time. This allows your Therapist to effectively assist other patients who may be in need of services. Depending on the day's schedule, the Therapist has the discretion to reschedule you that day. If you know that you will be unable to make your scheduled appointment, please call to cancel so that we can schedule another patient in your time slot. If you cancel an appointment within 24 hours of your appointment time, or do not come to your appointment, you will be sent a letter reminding you of each missed appointment. Once you've missed four appointments without proper notice, you may receive a letter discharging you from your therapy. We reserve the right to bill you $20.00 for missed appointments.

Co-payments - Copayments are due at the start of each treatment session. Your co-pay is decided by your insurance provider and we are not permitted to waive copayments. Authorization Coordinators are available to assist you with questions regarding your co-payment. If you require a payment plan, you may speak with our billing department staff.

Email - By providing your e-mail address above, you are agreeing to receive at such e-mail address (1) e-mails requesting your participation in surveys about your care, and (2) e-mails providing you with information regarding access to the FollowMyHealth patient portal.

Resuming Therapy - To resume therapy after being discharged, a new prescription from your Physician is required. Additionally, your insurance provider may require you to obtain a new referral.

Signature:_____ Date: _____ Time:_____

INFORMED CONSENT FOR PHYSICAL THERAPY / OCCUPATIONAL THERAPY / SPEECH-LANGUAGE PATHOLOGY

Physical, Occupational, and Speech-Language Pathology involve the use of many different types of evaluations and treatment procedures to help improve your function. As with all forms of treatment, there are benefits and risks involved. The possibility exists that your condition may not improve or could get worse. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response. Your treatment plan is based on your history, diagnosis, symptoms, testing results and functional needs. At any time, you have the right to discuss with your therapist your treatment as well as the risks, benefits and likelihood of achieving your therapy goals. You have the right to decline any portion of your treatment at any time before or during your treatment session. **I acknowledge that my treatment program has been explained including the likelihood of achieving goals of care, and all of my questions have been answered to my satisfaction. I understand the risks associated with a rehabilitation program as outlined to me, and I wish to proceed.**

Patient/Guardian/Relative's Signature	Date	Time	Print Name and Relationship to Patient
Clinician Signature	Date	Time	

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Patient Name: _____ Date of Birth: _____

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: _____ Date: _____

PATIENT/FAMILY SELF-REPORTED HOME MEDICATION LIST