

**TIDELANDS HEALTH REHABILITATION
MEDICAL HISTORY FORM**

Name: _____

Birth Date: _____

Emergency Contact: _____

Telephone Number: _____

Referring Physician: _____

Current _____ Current _____
Height: _____ Weight: _____

Past Medical History: *(Please check all that apply and answer questions below)*

- | | | | | |
|--|---|--|-----------------------------------|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> MRSA | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Stroke | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Visual Impaired | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |

Other Medical History: _____

Previous surgeries: _____

Allergies (list): _____

Current medications: Yes No Please list: _____

Race/Ethnicity: American Indian Asian Black/African American Caucasian Hispanic/Latino Native Hawaiian Other

Social History:

Current living arrangement: Private Home Assisted Living Senior Citizen Home Other: _____

Current household occupants: Alone Spouse Children Others: _____

Are you a caregiver for any of these occupants: Yes No

Do you have transportation concerns? Yes No

Are you a current smoker or tobacco user? Yes No

Have you recently experienced abuse or neglect? Yes No

(physical, emotional/psychological, neglect, sexual, abandonment, financial/material exploitation, unwarranted control)

Do you have feelings of / or plan to harm yourself or commit suicide? Yes No

Are you being treated by home health services? Yes No

Have you fallen the in past year? Yes No

How many times have you fallen in the past one year? _____

Did you sustain an injury when you fell? If so, please describe: _____

Are you using any assistive devices at this time? No Yes -> Cane Walker Wheelchair

Have you lived in or traveled outside of the United States within the past 14 days? Yes No

If yes, where: _____

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy at Tidelands Health Rehabilitation Services, a family member of the Georgetown Memorial or Waccamaw Community Hospital Systems.

Patient Signature: _____

Date _____

Name: _____

Birth Date: _____

Reason coming to therapy (body part / problem): _____

What do you hope to achieve from therapy (your goals)? _____

Current surgery: _____

Date of Surgery: _____

Who have you seen for this issue: Doctor Other Therapy Chiropractor Other: _____

Have you been treated in therapy for this same issue? Yes No

Please circle one: Right Handed Left Handed

Current pain level: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

Are Symptoms:

Getting better Not changing Getting worse

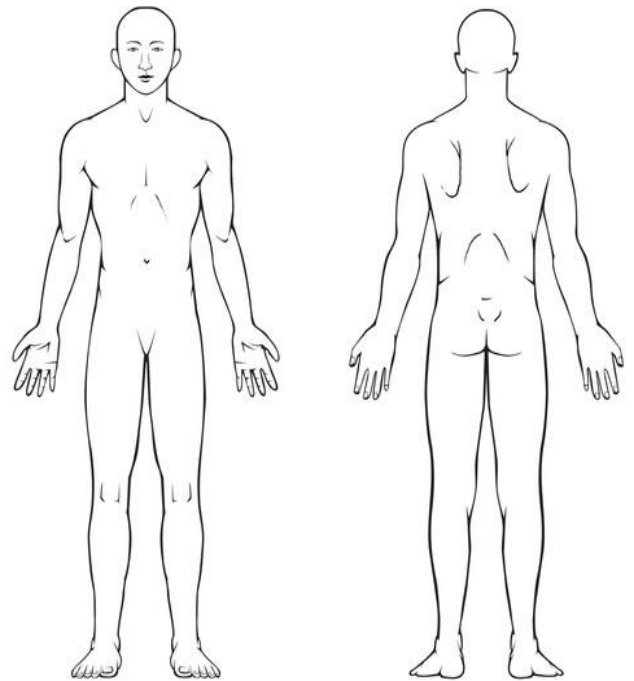
Pain Type:

Burning Stabbing Shooting Aching

Throbbing Other: _____

What increases your pain: _____

What decreases your pain: _____



Please indicate the location of pain or symptoms

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy at Tideland Health Rehabilitation Services, a family member of the Georgetown Memorial or Waccamaw Community Hospital System.

Patient Signature: _____

Date _____

TIDELANDS HEALTH REHABILITATION SERVICES

Welcome to **TIDELANDS HEALTH REHABILITATION** in The Market Common. Our therapists are dedicated to providing you with the maximum benefits of rehabilitation therapy. The goal of all therapies provided is to help each patient achieve their highest level of ability through any available treatments. The following are guidelines that we hope you will follow for you to receive maximum benefit through your plan of care.

- During your initial visit, you and your therapist will establish treatment goals to be achieved during your rehabilitation.
- Consistent attendance for all scheduled rehabilitation appointments is required.
- You may receive an appointment reminder by text message. Based on your cell phone plan standard text messaging rates may apply. You are able to opt out of this service at any time.

Personal Cell # _____

- Smart phone
- Not a smart phone

- **PLEASE be on time.** If you are 15 minutes late, we may have to reschedule your appointment. Please call ahead if you know that you will be late. We might be able to schedule you for a different time in the same day.
- If you need to cancel an appointment, please do so **at least 24 hours** in advance.
- If you do **not show for 3 appts.**, you may be **discharged** from therapy services and your physician will be notified.
- Your therapist will instruct you in a home exercise program. It is important that you follow the instructions given to you to receive maximum benefit from your therapy.
- We will send periodic updates or progress notes to your physician.
- You may be asked to provide your full name and date of birth to confirm your identity to the staff member escorting you to your treatment.

The goal of our staff is to provide excellent service and care for each patient on an individual basis. We will assist you in every way to achieve a positive outcome.

Patient Name (Print): _____

Patient/Guardian Signature: _____

Date: _____

Witness: _____

Date: _____



Patient Payment Responsibility Form

As a courtesy to our patient's, Tidelands Health Rehabilitation Services will be contacting your insurance provider to determine outpatient rehabilitation coverage information.

- Patient will be provided a copy of their insurance benefit information prior to starting their first visit of rehabilitation service. The coverage determination does not guarantee payment by your insurance plan.
- Patient will be responsible for any additional payments not covered by their insurance provider. This includes all applicable premiums, deductibles, and / or co-payment for each visit
- Patient is responsible for knowledge of their insurance coverage for outpatient hospital based physical therapy, occupational therapy, and / or speech therapy services.
- According to your insurance provider you are:

_____ eligible for outpatient rehabilitation benefits at this time

_____ not eligible for outpatient rehabilitation benefits at this time

- A patient may qualify for available discounts. Please ask the receptionist for more information.
- Medicare covers hospital based outpatient rehabilitation at 80%

Common Insurance Terms

Deductible: A set amount of money you will pay before the insurance coverage starts paying for services

Coinsurance: After the deductible is met this will be your share of the costs. It is usually configured into a percentage

Copay: A fixed amount you pay at the time of a particular type of service

Allowable: Maximum amount the insurance company will pay for a specific service. If the provider charges more than the allowed amount you may have to pay the difference. A preferred provider may not balance bill you.

Agreement

I agree to assist with tracking my insurance coverage allowed by my insurance company. If there is a discrepancy in coverage, I will alert a representative of Tidelands Health Rehabilitation Services immediately.

Please sign below to acknowledge and agree with the information provided above.

Patient/Guardian Signature: _____

Date: _____

Witness: _____

Date: _____



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name:

Date:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score:

Interpretation

- None- Minimal Depression**
- Mild Depression**
- Moderate Depression Moderately**
- Severe Depression Severe**
- Depression**

Interpretation of Total Score for Depression Severity

- 0-4 None-Minimal depression ● 5-9 Mild depression ● 10-14 Moderate depression ● 15-19 Moderately severe depression ● 20-27 Severe depression



Tidelands Health Rehabilitation Services

AUDIT-C

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

- a. Never
- b. Monthly or less
- c. 2-4 times a month
- d. 2-3 times a week
- e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- a. 1 or 2
- b. 3 or 4
- c. 5 or 6
- d. 7 to 9
- e. 10 or more

3. How often do you have six or more drinks on one occasion?

- a. Never
- b. Less than monthly
- c. Monthly
- d. Weekly
- e. Daily or almost daily

For Office use Only

Total Score: _____

a= 0 points, b= 1 point, c= 2 points, d= 3 points, e= 4 points

The Audit-C is scored on a scale of 0-12

Men = score of 4 or more is positive

Women = score of 3 or more is positive