TIDELANDS HEALTH REHABILITATION
MEDICAL HISTORY FORM

Name: _____ Birth Date: _____

Emergency Contact: _____ Telephone Number: _____

Referring Physician: _____ Current Height: _____ Current Weight: _____

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

__ Osteoarthritis	__ HIV / Aids	__ Pacemaker	__ Diabetes	__ Heart Disease
__ MRSA	__ Osteoporosis	__ Tuberculosis	__ Fainting	__ Epilepsy
__ High Blood Pressure	__ Asthma	__ Joint Replacement	__ Stroke	__ Headaches
__ Pregnancy	__ Hearing Impaired	__ Visual Impaired	__ Cancer	

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 to a country with widespread Ebola transmission or had contact with an individual with confirmed Ebola Virus Disease (EVD) within the previous 21 days? Yes No

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: _____

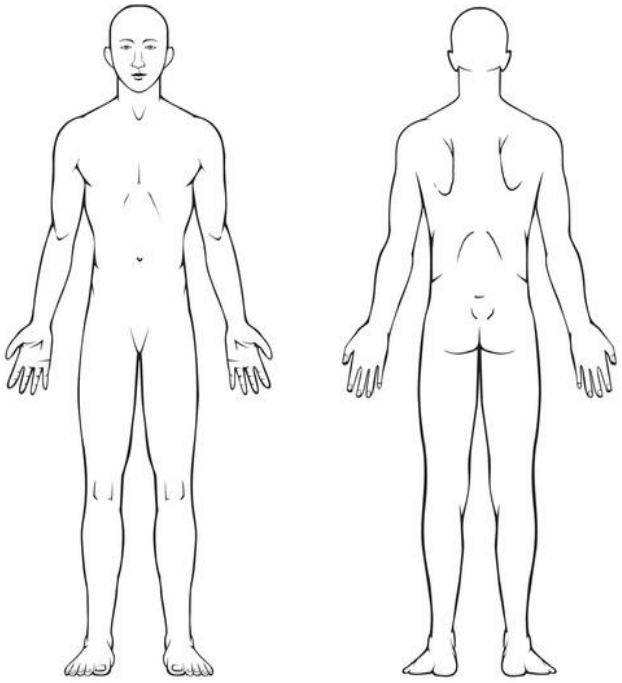
_____

_____

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 Tidelands 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** (A part of Waccamaw Community Hospital). 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 deducible 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 many 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: _____

Tidelands Health Rehabilitation Services

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	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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