RESTON THERAPY AND FITNESS CENTER PATIENT REGISTRATION FORM

Referring Physician's Name: _____ Phone: _____
Primary Physician's Name: _____ Phone: _____

PERSONAL INFORMATION

Patient's Name: _____ Name you go by: _____
Address: _____
City: _____ State: _____ Zipcode: _____
Home phone: _____ Cell Phone: _____ Work: _____
Date of Birth: _____ Age: _____ SSN: _____-_____-_____
Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Do you have a living will? ❑ YES ❑ NO
Have you been out of the country within the last 10 days? ❑ YES ❑ NO
Are you currently participating in a research study? ❑ YES ❑ NO

MEDICARE INFORMATION (if applicable)

What is your retirement date? _____
What is your significant other's retirement date? _____
Have you been hospitalized within the last 2 months? ❒ YES ❒ NO
If YES, which hospital? _____(Name)_____(City/State)
Admission date (to hospital): _____ Discharge date (from hospital) _____

NEXT OF KIN

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zipcode: _____
Home phone: _____ Cell Phone: _____ Work: _____

EMPLOYMENT INFORMATION

Are you currently working? ❒ YES ❒ NO If no, is it due to your condition? ❒ YES ❒ NO
Employer's Name: _____
Employer's Address: _____
City: _____ State: _____ Zipcode: _____
Work phone: _____ Extension: _____

INSURANCE INFORMATION

Subscriber's Name: _____ SSN: _____-_____-_____
Relationship to Subscriber: _____ Subscriber DOB: _____
Insurance Company: _____
Address for Billing: _____
City: _____ State: _____ Zipcode: _____
Member ID/Subscriber ID: _____ Group/Policy: _____
Insurance Phone # _____

WORKER'S COMPENSATION (IF APPLICABLE)

Date of occurrence/injury: _____
Case Manager Name & Phone: _____ _____
Claim Number: _____

_____ _____ _____
Patient Signature (or Legal Representative) (Relationship) Date

Reston Hospital Center
Reston Therapy & Fitness Center

Off Campus Medicare Outpatient Coinsurance Notice

To our Medicare patients;

Medicare regulations require us to provide you with a notice of your potential financial liability for the hospital service(s) you will receive.

Since the exact type and extent of care needed is not known, we are required to advise you that, because the service(s) are furnished by a department of Reston Hospital Center, you will incur a coinsurance liability to the hospital that you would not incur if the services were furnished in an entity that is not hospital-based.

The coinsurance liability to the hospital is in addition to any Medicare coinsurance liability for physician/professional services provided in conjunction with the hospital services.

I have read the foregoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law.

_____ _____

Signature of patient/authorized representative Date

OPTIMAL INSTRUMENT

CONFIDENCE BASELINE

Instructions: Please circle the level of confidence you have for each activity today.	Fully confident in my abilty to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking-short distance	1	2	3	4	5	9
11. Walking-long distance	1	2	3	4	5	9
12. Walking-outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

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PT

Reston Therapy and Fitness
OPTIMAL - Confidence Baseline

777.111 06/28/2013

PATIENT LABEL

OPTIMAL INSTRUMENT

DIFFICULTY BASELINE

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying Flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking-short distance	1	2	3	4	5	9
11. Walking-long distance	1	2	3	4	5	9
12. Walking-outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

*****Please complete all 22 items. This is an insurance requirement.*****

Also, please answer the following required question:

Do you feel safe in your home environment? ☐ YES ☐ NO

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Reston Therapy and Fitness
OPTIMAL - Difficulty Baseline

PATIENT LABEL

Outpatient Summary List

Date: **HT: _____ft. _____in WT: _____lbs.**

ALLERGIES
Meds:
Food:
Other:

Diagnoses/Medical Conditions:

Operative/Invasive Procedures:

Source of Medication List: *(check all that apply)*

- ❑ **Patient/Family Recall**
- ❑ **Patient Medication List**
- ❑ **Other:** *(Specify)* _____

Check Release for Reconciliation:

- ❑ **Outpatient Pre-op/Pre-Procedure Assessment**
- ❑ **Outpatient Treatment**

A complete Medication List must include: Name, Dose, Route and Frequency

Name of Medication (Current, over the counter, herbal)	Dose Route Frequency	Date/Time Medication last taken	Purpose of Medication	Medication Reviewed and Acknowledged
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

Please sign below:

Patient/Legal Representative: _____ **Date/Time:** _____

Nurse/Tech/Therapist: _____ **Date/Time:** _____

REHAB

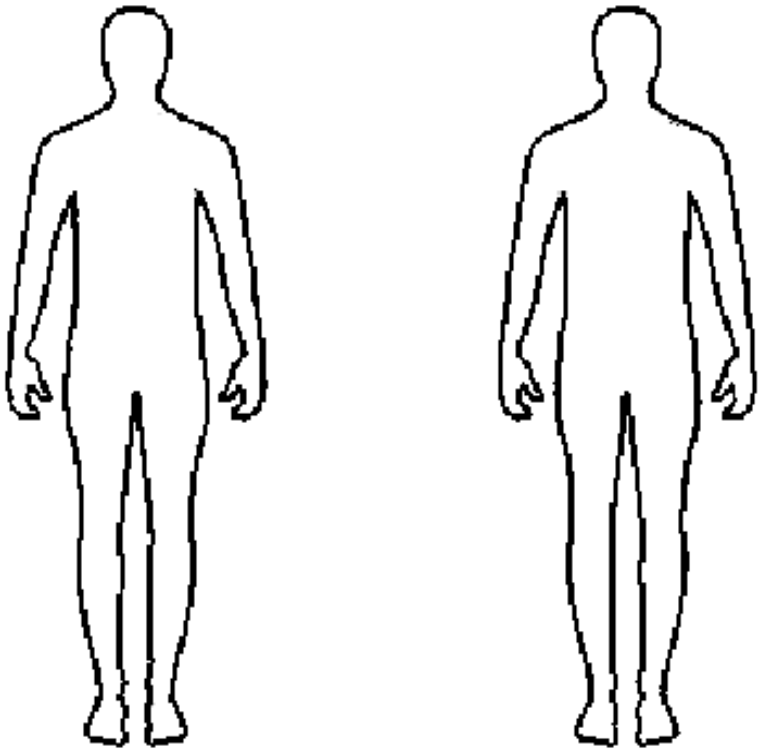
Pain Drawing

KEY	
///////	Pain
XXXX	Burning
0000	Pins &
====	Numbness
++++	Aching

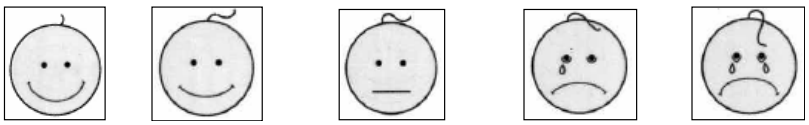
Dominant Hand:
___Right Handed
___ Left Handed

Is your pain intermittent (comes and goes) ?___
Constant (24 hours)? ___
What specific activities cause pain?
_____
_____
_____
_____
*Is there anything you can do to eliminate or decrease the Pain?*_____
_____
_____
_____
_____

Front ***Back***



0 No pain
1 Slight occasional pain
2 Mild pain; you are aware of it but it does not limit activities
3-4 Uncomfortable pain that minimally limits activities
5-6 Distressing pain that moderately limits activities
7-9 Intensely severe pain
10 Worse pain imaginable significantly limits your activities



0 1 2 3 4 5 6 7 8 9 10

CIRCLE YOUR CURRENT PAIN LEVEL

Date_____ Signature: _____

RESTON THERAPY AND FITNESS
PAIN SCALE

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PATIENT LABEL

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