## 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.

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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.

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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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**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:** _____

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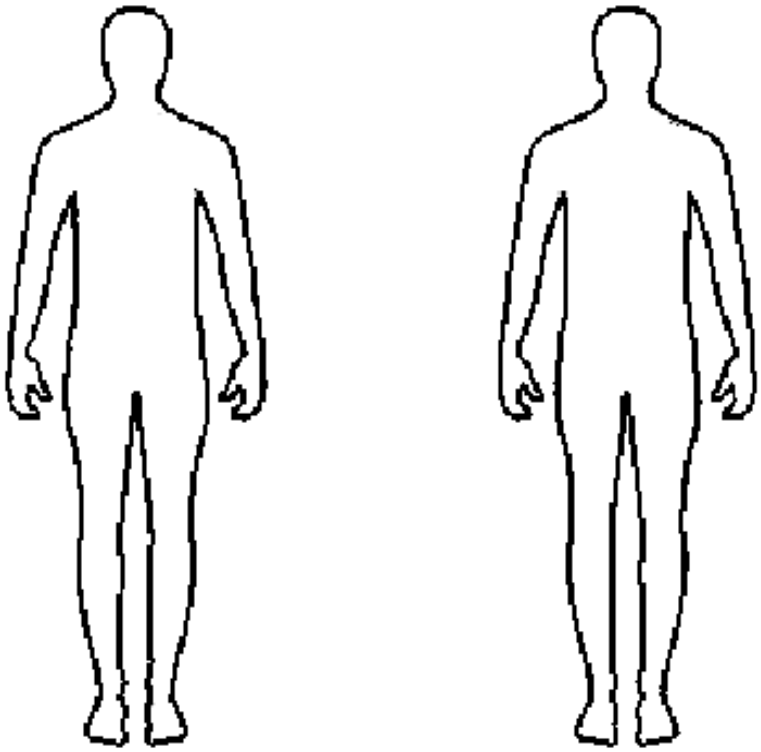
# Pain Drawing

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

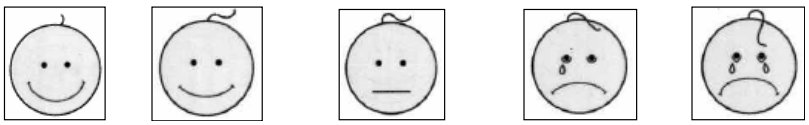
Dominant Hand:
___Right Handed
___ Left Handed

*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**

***REHAB***