LAKE CENTRE for REHAB

NEW PATIENT INFORMATION SHEET

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN ☐ WEBSITE ☐ FACEBOOK
☐ SEMINAR ☐ NEWSPAPER AD ☐ FRIEND ☐ RETURNING PATIENT ☐ OTHER_____

Name (First)_____(Middle)_____(Last)_____(Suffix)_____

Mailing Address_____

(City)_____(State)_____(ZIP)_____

Phone: Home_____Cell_____Work_____

Primary Phone _____Email Address_____

Date of Birth_____Age_____Marital Status: ☐Married ☐Divorced ☐Single ☐Other ☐ Unknown

☐Widowed ☐Separated Gender: ☐Male ☐Female Social Security #_____

Driver License #_____

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Self-Employed ☐Retired ☐Active Military ☐Unknown ☐Full Time Student

In case of emergency, please notify_____Phone_____

Attorney involvement? ☐Yes ☐No Attorney name_____Phone_____

Name of Employer, Parent or Guarantor_____

Street Address of Employer or Parent_____

City, State and ZIP of Employer or Parent_____

Name of Spouse_____Spouse Date of Birth_____

Spouse's Employer_____Phone_____

Have you received any therapy this year? ☐Yes ☐No

Have you been seen for nursing or physical therapy services in your home by a Home Health Agency prior to requesting services through our organization? ☐Yes ☐No If yes, name of home health agency_____

_____

Primary Care Provider/Family Doctor_____Phone_____

****

The two documents listed below are available for review at the Lake Centre for Rehab front office.

1. Authorization for Treatment, Assignment of Benefits, Payment Responsibility and Disclosure of ALF Resident Information.
2. Acknowledgement of Receipt of Privacy Notice in combination with Voluntary Consent.

The listed individuals may have access to my PHI (Protected Health Information): _____

_____

_____ _____

Patient/Representative Signature Date Witness Date

_____ _____

Guardian Signature if patient is a minor Date Relationship to Patient

LAKE CENTRE for REHAB

SCREENING FORM

Patient Name _____ Facility _____

Effective January 1, 2019, the Medicare "Cap" starts at $2,040 for physical and speech therapy services combined, and $2,040 for occupational therapy services, billed by an outpatient provider. Each provider is required to track the entire therapy episode, regardless of setting. When the Cap exceeds $3,000, there may be additional scrutiny of the claim by Medicare for medical necessity. Services can only be denied for medical necessity reasons.

Previous Therapy

1. Since the first of the year, have you received Part B therapy services in a skilled nursing facility?
   □ Yes □ No If yes, by whom and how much?_____
   _____
2. Since the first of the year, have you received Part B therapy services in a physician's office?
   □ Yes □ No If yes, by whom and how much?_____
   _____
3. Since the first of the year, have you received Part B therapy services in an outpatient clinic?
   □ Yes □ No If yes, by whom and how much?_____
   _____
4. Since the first of the year, have you received Part B therapy services in your home? □ Yes □ No
   If yes, by whom and how much?_____
   _____

Previous Home Health

Are you currently receiving home health services for nursing, or physical, occupational or speech therapy, from a home health agency? □ Yes □ No

Signing below indicates that the answers above are true and correct, and that the information is complete to the best of the signor's knowledge.

Patient Signature _____ Witness Signature _____

Date _____ Date _____

LAKE CENTRE for REHAB

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient_____

Medicare #_____ Admit/Eval Date_____

Facility_____ Provider #_____

1. Is the patient covered by Veterans Administration or Black Lung? ☐ Yes ☐ No

2. Was illness due to an injury? ☐ Yes ☐ No If yes,

   a. Date of accident_____
   b. What type of accident cause your illness/injury?_____
      _____
   c. Is the patient filing or intending to file a liability suite?_____
      If yes, please give name and address of attorney_____
      _____

3. Is the patient employed (Medicare disabled beneficiaries under the age of 65 or Medicare over the age of 65) and covered by a group health plan? ☐ Yes ☐ No

   a. Date of retirement_____
   b. Is the patient married?_____
   c. Is the spouse currently employed?_____
   d. Does the spouse have group coverage?_____
   e. Does the patient have coverage through a spouse, parent or guardian's employer group health plan?_____

4. Is the patient entitled to benefits solely on the basis of end stage renal disease? ☐ Yes ☐ No Has the patient been undergoing kidney dialysis for more than 12 months? ☐ Yes ☐ No

If you answered yes to any of the above questions, you will need to fill out the information requested below.

Insurance company_____

Address_____

Policy/certificate number_____

Group name_____

Group number_____

PATIENT SIGNATURE_____ DATE_____

RESPONSIBLE PARTY SIGNATURE_____ DATE_____

Relationship to patient_____

Signature of person completing this form_____ Date_____
(If other than the patient)

LAKE CENTRE for REHAB

Patient Name_____ **Date**_____

Female Pelvic Floor Questionnaire

Conditions related to the pelvic floor muscles can affect bladder, bowel, sexual, and physical function. Please answer the questions below so that we can better understand your problem.Please check all that apply.

History of Current Condition

Reason for today's visit_____
How long have you had this problem?_____
Since the problem began, has the problem become: ❑ Worse ❑ Better ❑ Unchanged
Is it related to an injury or accident? ❑ No ❑Yes Explain how and when_____
What are your goals for treatment?_____

Previous **Treatments** for your condition:

❑ Kegel exercises	❑ Rectocele repair	❑ Tubal ligation	❑ Massage therapy
❑ Biofeedback	❑ Hemorrhoid repair	❑ Infertility treatments	❑ Chiropractor
❑ Pelvic floor rehab	❑ Radiation	❑ Removal of endometria	❑ Acupuncture
❑ Diet/fluid changes	❑ Ostomy pouch	❑ Removal of adhesions	❑ Vaginal dilators
❑ Pessary	❑ Hemorrhoid cream	❑ Hysterectomy	❑ Over the counter pain meds
❑ Bladder surgery	❑ High fiber diet	❑ Abdominal	❑ Prescription pain meds
❑ Bladder control meds	❑ Probiotics	❑ Vaginal	❑ Bladder instillations
❑ Collagen injections	❑ Stool softeners	❑ With bladder repair	❑ Urethral/bladder dilation
❑ InterStim	❑ Constipation meds	❑ One ovary removed	❑ Nerve injections/blocks
❑ Self-catheterization	❑ Anti-diarrheal meds	❑ Both ovaries removed	❑ Other_____
❑ BCG	❑ Herbal supplements	Reason_____	
	❑ Enemas	Age_____	

Have you received therapy for the current or other problem in the past year? ❑ Yes ❑ No If yes, indicate type (physical therapy, speech therapy, etc.) and date_____

Previous **Tests** for your condition:

❑ Urodynamics study	❑ Video defacography	❑ X-ray	❑ Hysteroscopy
❑ Bladder scan (PVR)	❑ Colonoscopy	❑ CT scan	❑ Potassium test
❑ Cystoscopy	❑ Anal manometry	❑ MRI	❑ Exploratory surgery

Medical Conditions and Health Status

Please rate your overall health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
With whom do you live? ❑ Alone ❑ Spouse/significant other ❑Other relative(s) ❑ Roommate(s)
Where do you live? ❑ Private home or apartment ❑ Independent living ❑ Assisted living ❑Other_____

Bladder	❑ Urinary incontinence	❑ Small bladder capacity	❑ Bladder cancer	❑ Bladder infections (UTI's)
	❑ Overactive bladder	❑ Large bladder capacity	❑ Interstitial cystitis	❑ Painful bladder syndrome
	❑ Urinary retention	❑ Fallen bladder (cystocele)	❑Other_____	
Bowels	❑Fecal incontinence	❑Ulcerative colitis	❑ Hemorrhoids	❑ Colon cancer
	❑Constipation	❑Spastic colon	❑Lactose intolerance	❑ Anal cancer
	❑Diarrhea	❑Diverticulitis	❑ Gluten intolerance	❑ Colostomy/ileostomy
	❑Irritable bowel synd.	❑ Diverticulosis	❑Other_____	
Obstetrical	_____ Number of pregnancies		❑ Vaginal tear	
	_____ Number of vaginal deliveries		❑ Episiotomy	
	_____ Number of C-Section deliveries		❑ Vaginal stitches	
	_____ Weight of largest baby		❑ Use of forceps or suction	
	I'm pregnant now; due date_____		❑ Other complications_____	

Patient signature_____

LAKE CENTRE for REHAB

Patient Name_____ **Date**_____

Gynecological

- ❑ Endometriosis
- ❑ Vulvodynia
- ❑ Vaginismus
- ❑ Pudendal neuralgia
- ❑ Cervical cancer
- ❑ Ovarian cancer
- ❑ Uterine cancer
- ❑ Yeast infections
- ❑ Ovarian cysts
- ❑ Uterine fibroids
- ❑ Uterine prolapse
- ❑ Bladder (cystocele)
- ❑ Rectum (rectocele)
- ❑ "Falling out" feeling
- ❑ Bulge in the vagina
- ❑ Other_____

Menstruation Status

- ❑ Normal periods
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Peri-menopausal
- ❑ Post-menopausal
- ❑ Hysterectomy

Use of Hormones

- ❑ None used
- ❑ Birth control pills
- ❑ Estrogen replacement
  - ❑ Oral medication
  - ❑ Skin patch
  - ❑ Vaginal cream
  - ❑ Suppository

Sexual Function: ❑ I'm sexually active

❑ I'm not sexually active due to: ❑ My pelvic pain symptoms ❑ For non-health related reasons ❑ *My other* medical problems ❑ *My partner's* medical problems

Other Medical

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Heart attack
- ❑ Angina
- ❑ Congestive heart failure
- ❑ Cardiac arrhythmia
- ❑ Pacemaker/defibrillator
- ❑ Vascular disease
- ❑ Swollen legs/edema
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Asthma
- ❑ Cigarette smoker
- ❑ Former smoker
- ❑ Migraine headaches
- ❑ Stroke
- ❑ TIA (mini strokes)
- ❑ Parkinson's Disease
- ❑ Multiple Sclerosis
- ❑ Seizures
- ❑ Hypothyroidism
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Sleep apnea
- ❑ Diabetes
- ❑ Acid reflux
- ❑ Depression
- ❑ Anxiety disorder
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Glasses
- ❑ Hearing loss
- ❑ Fibromyalgia
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Low back pain
- ❑ Tailbone trauma
- ❑ Sciatica
- ❑ Stenosis
- ❑ Arthritis Area_____
- ❑ Herniated disc Level_____
- ❑ Degenerative disc Area_____
- ❑ Bone fracture Area_____
- ❑ Cancer Area_____
- ❑ Other_____

Surgeries	Age or Year	Medications	For what condition?

Allergies

❑ None ❑ Latex sensitivity ❑ Seasonal (pollen/hay fever) ❑ Bees ❑ Other_____

❑ Food_____ ❑ Medications_____

Review of Systems - Please check if you have you recently had any of these symptoms.

- ❑ Fever/chills
- ❑ Weight change
- ❑ Fatigue/night sweats
- ❑ Skin rash/itch
- ❑ Headaches
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Ear pain/discharge
- ❑ Nose bleeds
- ❑ Sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Light sensitive
- ❑ Eye pain/redness
- ❑ Chest pain
- ❑ Pounding heart
- ❑ Shortness of breath
- ❑ Calf pain
- ❑ Leg swelling
- ❑ Cough
- ❑ Coughing up blood
- ❑ Phlegm production
- ❑ Congestion
- ❑ Wheezing
- ❑ Heartburn
- ❑ Nausea/vomiting
- ❑ Stomach pain
- ❑ Bloody stools
- ❑ Tarry stools
- ❑ Blood in urine
- ❑ Muscle pain
- ❑ Neck/back pain
- ❑ Joint pain
- ❑ Falls
- ❑ Arm/leg weakness
- ❑ Lack of coordination
- ❑ Difficulty walking
- ❑ Difficulty standing up
- ❑ Tingling/numbness
- ❑ Tremors
- ❑ Speech changes
- ❑ Seizures
- ❑ Loss of consciousness
- ❑ Vertigo/spinning
- ❑ Unsteadiness
- ❑ Lightheaded
- ❑ Depression
- ❑ Nervous/anxious
- ❑ Suicidal thoughts
- ❑ Hallucinations
- ❑ Substance abuse
- ❑ Memory loss

Is your doctor aware of these recent symptoms? ❑ Yes ❑ No

Patient signature_____

LAKE CENTRE for REHAB

Patient Name_____**Date**_____

Please answer the questions below. If your symptom severity fluctuates, characterize your symptoms at their worst.

Bladder Health Do you have a urologist? ❑ Yes ❑ No If yes, who?_____

1. During the **daytime**, how often do urinate? ❑ Every 30-60 minutes ❑ 1-2 hours ❑ 2-3 hours ❑ 3-4 hours ❑More than 4 hours
2. During the **nighttime** (after you've fallen asleep), how often do you get up to urinate? ❑ 0-1 times per night ❑2-3 times ❑ 3-4 times ❑More than 4 times
3. How many **8 ounce servings** (cups) do you drink of the following?

Liquid	Per Day	Per Week	On Occasion	Never	Liquid	Per Day	Per Week	On Occasion	Never
Coffee (❑ Reg. ❑ Decaf)					Water				
Tea (❑ Reg. ❑ Decaf)					Milk				
Soda (❑ Reg. ❑ Decaf)					Juice				
Beer/Wine/Liquor					Other_____				

4. Do you **every lose urine (even a few drops)** with any of the situations below?

	Never	On Occasion	Sometimes	Usually	Always
Cough					
Sneeze					
Laugh					
Getting out of a chair					
Getting out of a car					
Getting out of bed at night					
Getting out of bed in the morning					
Picking objects off the floor					
Putting on shoes or clothes					
Lifting light items					
Lifting heavy items					
Cooking or doing dishes					
Doing housework					
Doing yard work					
During sexual activity					
Walking to the toilet at home					
Shopping or running errands					
Standing or walking for a long time					
Walking to toilet in public					
Recreational activities					
Exercise activities					
Other_____					

5. Do you ever have **strong or difficult-to-controlurges** to urinate with the situations listed below?

	Never	On occasion	Sometimes	Usually	Always
Around running water					
Feeling cold					
Feeling anxious or nervous					
Unlocking the door					
If I've waited too long					
Rushing off to the toilet					

Patient signature_____

LAKE CENTRE for REHAB

Patient Name_____ **Date**_____

6. How long can you **usually delay an urge** to urinate? ❑ I rarely feel urges to void ❑ I go as soon as I feel an urge ❑ 1-2 minutes ❑Several minutes ❑ 10-15 minutes ❑ 15 minutes or more
7. What **type of protective padding**do you use for bladder control? ❑ None needed ❑ Change underwear ❑ Folded tissue paper ❑ Liners ❑ Thin pads ❑ Thick pads ❑ Diapers ❑ Other_____
8. How often do you **change your bladder protection**? ❑None ❑Only when I leave the house ❑ Only at night ❑ Only during a cold ❑Only during exercise ❑ 1-2 per day ❑ 3-4 per day ❑ 4+ per day
9. How**saturated** does your protection get? ❑ No leakage ❑ "Near misses" ❑ A few drops ❑ Damp ❑ Wet ❑ Soaked ❑ Overflows onto clothes
10. How often do you go to the bathroom **before you feel urges** to void, "just in case?" ❑ Never ❑ On occasion ❑Sometimes ❑ Usually ❑ Always
11. How often do you **avoid drinking**fluid in order to help with bladder control? ❑ Never ❑ On occasion ❑Sometimes ❑ Usually ❑ Always
12. Do you ever notice any of the following **bladder symptoms**? Please check how often.

	Never	On occasion	Sometimes	Usually	Always
Weak stream					
Incomplete bladder emptying					
Trouble starting urine stream					
Strain to urinate					
Dribble after urinating					
Have to rock pelvis to empty bladder					
Have to push over the bladder to empty					
Splint or support bladder to urinate					
Pain as my bladder *fills*					
Location:	❑Bladder ❑Urethra ❑Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bladder *empties*					
Location:	❑Bladder ❑Urethra ❑Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

Bowel Health

Do you have a gastroenterologist? ❑ Yes❑ No If yes, who?_____

1. **How often** do you have a bowel movement? ❑ Less than 3 times a week ❑Every 2-3 days ❑ Every 1-2 days ❑ Daily ❑ 2-3 times per day ❑More than 3 times per day ❑ I won't go for several days, and then go multiple times in one day
2. What is the **consistency** of your bowel movements? ❑ Watery/formless ❑ Loose and thin ❑ Soft and formed ❑ Hard and rocky ❑ Small and pellet-like ❑It varies_____
3. Do you ever **lose feces** with any of the situations below? Please check how often.

	Never	On Occasion	Sometimes	Usually	Always
On the way to the toilet					
If I exert myself					
When I pass gas					
I have fecal soiling without an urge to have a BM					

4. What **type of protective padding**do you use for bowel control? ❑ None needed ❑ Change underwear ❑ Folded tissue paper ❑ Liners ❑ Thin pads ❑ Thick pads ❑ Diapers ❑ Other_____
5. How often do you **change your bowel protection**? ❑ None ❑Only when I leave the house ❑ Only when I have diarrhea/ loose stools ❑ 1-2 per day ❑ 3-4 per day ❑ 4+ per day

Patient signature_____

LAKE CENTRE for REHAB

Patient Name_____**Date**_____

6. Do you every notice any of the following **bowel symptoms**? Please check how often.

	Never	On occasion	Sometimes	Usually	Always
Excessive straining during a BM					
Support/splint rectum during BM					
Incomplete BM's					
Rush to the toilet with BM urge					
Trouble controlling gas in public					
Excessive wiping needed after BM					
Fecal soiling in underwear after BM					
Pain as my bowels *fill*					
Location:	❑Rectum❑Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bowels *empty*					
Location:	❑Rectum❑Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

GYN Health

Do you have an OB/GYN? ❑ Yes❑ No If yes, who?_____

Vulvar symptoms: ❑ Dryness ❑ Itching ❑ Discharge ❑ Numbness/tingling ❑ Redness ❑ Swelling

Pelvic pain symptoms: ❑None
❑My pelvic symptoms **affect my ability** to, OR **I feel worse when I try** to: Check all that apply.

❑ Sleep	❑Do yard work	❑ Get out of acar	❑Perform work duties
❑ Bathe	❑Bend forward	❑ Climb stairs	❑Recreational activities
❑ Get dressed	❑Squat down	❑ Sitting tolerance	❑Social events
❑ Wear tight clothing	❑Lift items	❑ Standing tolerance	❑Travel
❑ Wear a tampon	❑Reach overhead	❑ Walking distance	❑Exercise for health
❑ Cook meals	❑Get out of bed	❑ Drive a car	❑Have a GYN exam
❑ Do housework	❑Stand up from a chair	❑ Run errands/shop	❑Do Kegel exercises

Pain Location: Check all that apply.

❑ Abdomen	❑ Inner thighs	❑ Side/waist	❑ Over tight surgical scars	❑ Vagina
❑ Clitoris	❑ Urethra	❑ Bladder	❑ Tailbone	❑ Rectum
❑ Low back	❑ Buttocks	❑ Groin	❑ Sides of hips	❑ Back of hips
❑Front of hips				

Circle pain severity:No Pain 0___1___2___3___4___5___6___7___9___10 Worst Pain

Pain with sexual activity:

❑ None
❑I limit the *frequency* of sexual activity because of my pain.
❑ I have to *interrupt* intercourse due to pain.
❑ I *avoid it* altogether due to my pain. Last intercourse attempt: _____

The pain occurs during: ❑Vulvar touching❑Vaginal penetration❑Thrusting❑Orgasm
For how long?❑ Only during sexual activity ❑For a few hours afterwards❑ For a day or more afterwards
Location:❑Vaginal opening ❑Clitoris ❑ Deep in my pelvis❑In my back
Circle pain severity:No pain 0___1___2___3___4___5___6___7___9___10 Worst Pain

Patient signature_____

LAKE CENTRE for REHAB

INSTRUCTIONS

Before your first visit, download the patient forms from our website www.golcr.com/forms

On your first visit, please remember to bring the following:

1. Physician or NPP (Non-Physician Provider) order for therapy.
2. ***Bring the patient forms you filled out***
3. Insurance cards (primary and secondary).
4. Photo ID.
5. Current list of medicines and allergies.
6. Recent reports that you might have, including x-rays, MRI's, surgeries, etc.
7. Loose-fitting, comfortable clothing.
8. Supportive closed-toe shoes.
9. Bring in any adaptive devices currently used, such as braces, canes, walkers, etc.
10. Copy of home health discharge with name and phone number of home health agency if applicable.
11. Notify us of implants and pacemakers (defibrillators).

Due to allergies of staff members and patients, please refrain from strong fragrances.