The Rehabilitation Center
of
Charles A. Cannon, Jr. Memorial Hospital

Welcome to The Rehabilitation Center!

Thank you for choosing The Rehabilitation Center for your rehabilitation needs. We are dedicated to providing excellent clinical care, exceptional customer service and a patient centered approach which will help you to reach the best outcomes possible.

The Rehabilitation Center offers comprehensive Physical Therapy, Occupational Therapy and Speech-Language Pathology (SLP) services for a variety of conditions. Our services include individualized treatments for orthopedic conditions, neurological conditions, pain, difficulty walking, chronic pain and fatigue, balance issues, dizziness, cancer rehabilitation, hand therapy, speech and swallowing conditions and many other problems.

Our staff is committed to help you reach your goals and provide you with the best rehab experience possible!

Welcome to The Rehabilitation Center! We look forward to getting to know you!

The Staff of The Rehabilitation Center of
Appalachian Regional Healthcare System

Office Hours:
Monday – Friday: 8 a.m. - 4:30 p.m.
(828) 737-7520
434 Hospital Drive • Linville, NC
apprhs.org/rehab

THE REHABILITATION CENTER
of
CHARLES A. CANNON, JR. MEMORIAL HOSPITAL

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient History: to be completed by patient

Name:
_____

Sex: ☐ Male ☐ Female

Education:
Highest grade completed (circle one) 1 2 3 4 5 6 7 8 9 10 11 12
☐ Some college / technical school
☐ College graduate
☐ Graduate school / advanced degree

Social History:
Cultural / Religious: Any customs or religious beliefs or wishes that might affect care?
_____

With whom do you live:
☐ Alone
☐ Spouse only
☐ Spouse and other(s)
☐ Child (not spouse)
☐ Other relative(s) (not spouse or children)
☐ Group setting
☐ Personal care attendant
☐ Other: _____

Employment / Work (Job/School/Play)
☐ Working full time outside of home
☐ Working part-time outside of home
☐ Working full-time from home
☐ Working part-time from home
☐ Homemaker ☐ Student ☐ Retired ☐ Unemployed

Occupation: _____

Living Environment
Does your home have:
☐ Stairs, no railing
☐ Stairs, railing: 1 2
☐ Ramps
☐ Elevator
☐ Uneven Terrain
☐ Assistive Devices (eg, bathroom: _____
☐ Any obstacles: _____
_____

Where do you live:
☐ Private home
☐ Private apartment
☐ Rented room
☐ Board and care/assisted living / group home
☐ Homeless (with or without shelter)
☐ Long term care facility / nursing home
☐ Hospice

Family History

Outpatient Rehabilitation Evaluation

☐ PT ☐ OT ☐ SLP

Evaluation Date: _____

How did you hear about The Rehab Center?
☐ **Physician** ☐ **Website**
☐ **Friend or Family** ☐ **Advertisement**
☐ **Other:** _____

Social / Health Habits
Currently smoke / use tobacco? ☐ Yes ☐ No
Smoked in past? ☐ Yes ☐ No
Alcohol use? ☐ Yes ☐ No
Regular Exercise? ☐ Yes ☐ No

Current Condition / Chief Complaint(s)

Describe the problem (s) for which you seek therapy:
_____
_____

When did the problem(s) begin (mo/yr) _____/_____
What happened? _____
_____
_____
_____

Have you ever had the problem(s) before? ☐ Yes ☐ No
If yes, what did you do for the problem(s)? _____
_____
_____
Did the problem(s) get better? ☐ Yes ☐ No
How long did the problem(s) last? _____

How are you taking care of the problem(s) now? _____
_____
_____

What makes the problem(s) better? _____
_____
_____

What makes the problem(s) worse? _____
_____
_____

What activities and tasks were you able to do previously that because of this condition you are unable to do now?
1. _____
2. _____
3. _____

What are your goals for therapy?
1. _____
2. _____
3. _____

Surgeries

Effective Date: 01/08/2012
Revised Date: 04/07/2015
Form Number: 10691

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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Outpatient Rehabilitation Evaluation

- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Arthritis
- ☐ Hypertension
- ☐ Diabetes
- ☐ Psychological
- ☐ Osteoporosis
- ☐ Other:_____

Medical / Surgical History (Conditions)

Please check if you have ever had:

- ☐ Blood disorders
- ☐ Circulation / Vascular problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes/ high blood sugar
- ☐ Low blood sugar/ hypoglycemia
- ☐ Cancer
- ☐ Skin diseases
- ☐ Repeated infections
- ☐ Arthritis
- ☐ Broken bones/ fractures
- ☐ Osteoporosis
- ☐ Head Injury
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Seizures/epilepsy
- ☐ Developmental or growth problems
- ☐ Muscular dystrophy
- ☐ High cholesterol
- ☐ Thyroid problems
- ☐ Kidney problems
- ☐ Infectious disease
- ☐ Allergies
- ☐ Ulcers/stomach problems
- ☐ Depression
- ☐ Recent infection (cdiff, MRSA, VRE, ect.)
- ☐ Other:_____

Medical / Surgical History (Symptoms)

Within the past year, have you had any of the following symptoms? (check all that apply)

I. General Health System

- ☐ Fatigue
- ☐ Fever / chills/ sweats
- ☐ Nausea/ vomiting
- ☐ Change in sensation
- ☐ Weakness
- ☐ Balance/coordination issues
- ☐ Dizziness/Vertigo
- ☐ Malaise
- ☐ Pulsating Pain
- ☐ Persistent night pain

II. GI/Renal & Reproductive System

- ☐ Difficulty swallowing
- ☐ Heartburn/ Indigestion
- ☐ Food Intolerances
- ☐ Severe abdominal pain
- ☐ Changes in speech
- ☐ Loss of appetite
- ☐ Change in urinary frequency
- ☐ Pain with urination
- ☐ Incontinence
- ☐ Pain with intercourse
- ☐ Pregnant
- ☐ Menopause

III. Cardiovascular

- ☐ Dyspnea
- ☐ Palpitations
- ☐ Syncope/fainting
- ☐ Edema or swelling
- ☐ Unexplained cough
- ☐ Sever pain in calf
- ☐ Discolored, painful feet

IV. Pulmonary System

- ☐ Shortness of Breath
- ☐ Productive Cough
- ☐ Wheezing
- ☐ Clubbing of nails

V. Neurological System

- ☐ Frequent headaches
- ☐ Bowel dysfunction
- ☐ Vertigo
- ☐ Changes in hearing
- ☐ Unexplained falls
- ☐ Frequent ear infections

VI. Integumentary System(Skin)

- ☐ Discoloration
- ☐ Wounds
- ☐ Lacerations
- ☐ Bruises

Have you ever had surgery? ☐ Yes (please explain) ☐ No

_____

_____

Other Clinical Test Within the last year, have you had any of the following tests? (Check all the apply)

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bone scan
- ☐ Bronchoscopy
- ☐ CT Scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG(electroencephalogram)
- ☐ EKG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ ENG / calorics
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NCV (nerve conduction velocity)
- ☐ Pap smear
- ☐ Pulmonary Function Test
- ☐ Spinal tap
- ☐ Stool tests
- ☐ Stress test (eg. treadmill, bicycle)
- ☐ Urine tests
- ☐ X-rays
- ☐ Other: _____

Are you seeing anyone else for the problem(s)?

- ☐ Accupuncturist
- ☐ Audiologist
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ ENT
- ☐ Family practitioner
- ☐ Internist
- ☐ Massage therapist
- ☐ Home Health Services
- ☐ Neurologist
- ☐ OB/Gyn
- ☐ Occupational Therapist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Podiatrist
- ☐ Primary Care Physician
- ☐ Rheumatologist
- ☐ Other: _____

During the last 2 months have you been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

During that past month have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

Is this something that you would like help with? ☐ Yes ☐ No ☐ Yes, but not today

Have you had any major life changes during the past year? (eg, new baby, job change, death of a family member) ☐ Yes ☐ No

_____

Patient Signature **Date**

For Therapist use: _____

_____

_____

_____

Reviewed by Therapist:

Signature: _____ Date/Time: _____

Effective Date: 01/08/2012
Revised Date: 04/07/2015
Form Number: 10691

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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient Medication List and Summary List

Patient Name:_____ DOB:_____ SOC: _____

Current Medications / Dose	Physician	Changes to medication/ medical history/ surgeries during POC
☐ Medication List Attached		

Medication Allergies:_____

_____

_____

Latex allergy: ☐Yes ☐No

☐ **Reviewed by therapist:**

Signature:_____ Date:_____ Time:_____
Signature:_____ Date:_____ Time:_____
Signature:_____ Date:_____ Time:_____

Effective Date: 08/02/2012
Revised Date: 11/17/2015
Form Number: 10485

THE REHABILITATION CENTER
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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Authorization of Release and Consent

Name: _____ DOB: _____ Date last signed: _____

Persons authorized to receive information

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please indicate information that can be released	**How may we leave messages for you?**
☐ Medical (i.e. results of lab tests / x-rays) ☐ Appointment information ☐ Financial ☐ Other	☐ Voice mail _____ ☐ Email _____ ☐ Other _____ _____

Signature Page

- All of my registration information is true and accurate to the best of my knowledge.
- I acknowledge that I received the release of Medical Information and the Financial Information. I understand that I have the right to revoke this authorization at anytime. Revocation must be made in writing and will be effective from date of revocation.
- I have read/received a copy of Patient Rights and Responsibilities.
- I understand that because The Rehabilitation Center is owned by Charles A. Cannon Jr., Memorial Hospital, all PT, OT, and SLP services will be billed as a "facility". As a hospital-based facility, insurance companies view us differently than other outpatient rehabilitation providers. You will be responsible for the percentage of your bill not covered by your insurance policy (deductible and co-insurance). Because we bill as a facility, co-pays rarely apply.

_____

Signature of Patient / Legal Guardian Date

_____

Signature of Guarantor (if applicable) Date

_____

Description of Personal Representative's Authority (attach necessary documentation)

Effective Date: Not Set
Revised Date: 07/26/2019
Form Number: 11550