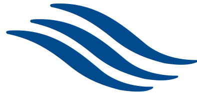

The Rehabilitation Center
of
Watauga Medical Center

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, women's health issues, cancer rehabilitation, hand therapy, lymphedema management, 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

Services Available through The Rehabilitation Center

Onsite services:
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Aquatic Therapy

Services available through consultation or referral:
- Transitional Programs for clients with Fibromyalgia and Lymphedema
- Prosthetic and Orthotic services
- Medical Equipment consultation
- Care Management Services
- Bioness Assessment Services
- THRIVE: medically supervised chronic disease management program

State of the Art Equipment includes:
- Aquatic Therapy pool
- Neuro-Com Smart Equitest to analyze balance, vestibular and orthopedic disorders
- Biofeedback
- Litegait Partial Weight Bearing System
- Bioness
- Flexitouch compression device for edema problems
- Saebo Splints
- Baltimore Therapeutic Equipment Simulator

Office Hours:
Monday – Friday: 8 a.m. - 5 p.m.

(828) 268-9043
232 A Boone Heights Drive • Boone, NC
apprhs.org/rehab

THE REHABILITATION CENTER
of
WATAUGA MEDICAL CENTER

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
☐ Other relative(s)
☐ Group setting
☐ Personal care attendant
☐ Other: ____________

Employment/Work/School
☐ Working full time
☐ Working part-time
☐ Retired
☐ Unemployed
☐ Homemaker
☐ Student
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

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

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

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. ____

Within the past 12 months, have you worried whether your food would run out before you got money to buy more?
☐ Yes ☐ No

Within the past 12 months has the food you bought not lasted and you didn't have money to get more? ☐ Yes ☐ No

Do you have concerns that transportation issues could affect your ability to come for therapy? ☐ Yes ☐ No

Effective Date: 08/01/2012
Revised Date: 09/30/2019
Form Number: 33961

THE REHABILITATION CENTER
of
WATAUGA MEDICAL CENTER

Patient Name________________________________
Date of Birth________________________________
Phone Number________________________________
Please Fill in or Affix a Patient Label

Outpatient Rehabilitation Evaluation

Family History

- ☐ 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

Surgeries

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 / caloric testing
- ☐ 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)?

- ☐ Acupuncturist
- ☐ 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: ________________________________

____

Patient Signature **Date**

For Therapist use: ________________________________

____

____

____

Reviewed by Therapist:

____

Signature **Date/Time**

Effective Date: 08/01/2012
Revised Date: 09/30/2019
Form Number: 33961

THE REHABILITATION CENTER of WATAUGA MEDICAL CENTER	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
☐ Medication List Attached	

Changes to medication/ medical history/ surgeries during POC

Medication Allergies:____

____

____

Latex allergy: ☐Yes ☐No

☐ **Reviewed by therapist:**

Signature:__________________________	Date:_________	Time:_________
Signature:__________________________	Date:_________	Time:_________
Signature:__________________________	Date:_________	Time:_________

Effective Date: 08/01/2012
Revised Date: 04/21/2020
Form Number: 00657

 THE REHABILITATION CENTER of WATAUGA MEDICAL CENTER	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 Watauga Medical Center, 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)