

**WATER WORKS TOTAL REHAB  
MEDICAL QUESTIONNAIRE**

**Please complete this questionnaire prior to beginning your initial evaluation and treatment program.  
Please do not leave any spaces blank. If the question does not apply, please write N/A.  
Thank you.**

NAME \_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

LOCAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

LOCAL PHONE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

OUT OF STATE ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

OUT OF STATE PHONE \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Business Ph# \_\_\_\_\_

Local contact name and phone # \_\_\_\_\_

Emergency contact name and phone # \_\_\_\_\_

Spouse's Place of Employment \_\_\_\_\_ Ph# \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse's SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

Person Responsible for payment \_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Home Ph# \_\_\_\_\_ Business Ph# \_\_\_\_\_

Insurance Co \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

2<sup>nd</sup> Insurance Co \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Family doctor \_\_\_\_\_ Referring doctor \_\_\_\_\_

How did you hear about Water Works Total Rehab? \_\_\_\_\_

ARE YOU CURRENTLY RECEIVING OR HAVE YOU HAD IN THE LAST THREE MONTHS, SERVICES FROM A HOME HEALTH AGENCY UNDER AN ACTIVE HOME HEALTH PLAN OF CARE? \_\_\_\_\_

If yes, please state the name of the agency. \_\_\_\_\_

Please place a checkmark ( ) if you presently have or have a history of any of the following.  
Please explain the item you have checked in the space available.

\_\_\_\_ HAVE YOU FALLEN IN THE PAST 3 MONTHS \_\_\_\_\_

\_\_\_\_ HEART \_\_\_\_\_

\_\_\_\_ SURGERY/PACEMAKER \_\_\_\_\_

\_\_\_\_ HEART DISEASE/CHESTPAIN/CARDIAC PRECAUTIONS \_\_\_\_\_

\_\_\_ HIGH OR LOW BLOOD PRESSURE \_\_\_\_\_ IS IT CONTROLLED? \_\_\_\_\_  
 \_\_\_ RESPIRATORY DISEASE/SHORTNESS OF BREATH/USE OXYGEN \_\_\_\_\_  
 \_\_\_ CIRCULATION PROBLEMS \_\_\_\_\_  
 \_\_\_ SURGERY (WHAT/WHEN?) \_\_\_\_\_  
 \_\_\_ JOINT REPLACEMENT(S) \_\_\_\_\_  
 \_\_\_ SEIZURES \_\_\_\_\_ LAST ONE? \_\_\_\_\_  
 \_\_\_ DIABETES \_\_\_\_\_ CONTROLLED? \_\_\_\_\_  
 \_\_\_ STROKE \_\_\_\_\_ WHEN? \_\_\_\_\_  
 \_\_\_ FAINTING OR DIZZINESS \_\_\_\_\_  
 \_\_\_ INFECTION \_\_\_\_\_  
 \_\_\_ OPEN CUTS/WOUNDS/INCISIONS \_\_\_\_\_  
 \_\_\_ MULTIPLE SCLEROSIS \_\_\_\_\_  
 \_\_\_ CONDITION THAT MAKES YOU HEAT SENSITIVE \_\_\_\_\_  
 \_\_\_ PREGNANT \_\_\_\_\_  
 \_\_\_ FEVER IN THE LAST THREE MONTHS \_\_\_\_\_  
 \_\_\_ EAR PROBLEMS (OF ANY KIND) \_\_\_\_\_  
 \_\_\_ BLADDER / BOWEL CONTROL PROBLEMS \_\_\_\_\_  
 \_\_\_ CHLORINE OR CHEMICAL SENSITIVITY \_\_\_\_\_  
 \_\_\_ CURRENT ATHLETES FOOT / PLANTAR WART / FOOT DISEASE \_\_\_\_\_  
 \_\_\_ FEARFUL OF WATER OR POOL? \_\_\_\_\_

ARE YOU AWARE OF ANY CONDITION OR LIMITATIONS THAT MAY AFFECT YOUR EXERCISING IN A POOL? \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

PLEASE READ AND SIGN THE FOLLOWING:

TO MY KNOWLEDGE I HAVE NO MEDICAL OR PHYSICAL CONDITIONS OR LIMITATIONS THAT WOULD NOT PERMIT ME TO VOLUNTARILY PARTICIPATE IN THE ONGOINGT POOL PROGRAMS. I HAVE BEEN ADVISED OF THE RULES AND REGULATIONS AND I MUST ADHERE TO THESE AT ALL TIMES WHEN PARTICIPATING IN THE WATER WORKS PROGRAM. I UNDERSTAND THAT MY PARTICIPATION IS VOLUNTARY AND THAT WATER WORKS WILL NOT BE HELD RESPONSIBLE FOR ANY INJURIES THAT MIGHT BE SUSTAINED DURING THIS PROGRAM, EXCEPTING ACT OF NEGLIGENCE.

I CERTIFY THAT THE ABOVE INFORMATION GIVEN BY ME IS TRUE AND CORRECT. I AUTHORIZE WATER WORKS TOTAL REHAB TO RELEASE INFORMATION CONCERNING MY MEDICAL CONDITION AND / OR PROGRESS IN THERAPY TO MY INSURANCE COMPANY, ATTORNEY'S OFFICE AND / OR PHYSICIAN REFERRING ME. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL OUTSTANDING BALANCES.

\_\_\_\_\_  
PATIENTS SIGNATURE OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE

## WATER WORKS FUNCTIONAL ASSESSMENT

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please mark the line of the statement that best describes how you feel for each of the sections below.

### SECTION # 1 PAIN

- \_\_\_\_\_ Pain does not limit my activities at all.
- \_\_\_\_\_ My activities are mildly limited by pain.
- \_\_\_\_\_ My activities are moderately limited by pain.
- \_\_\_\_\_ My activities are very limited by pain.
- \_\_\_\_\_ I am unable to do any activity due to pain.

### SECTION # 2 RISING FROM SITTING

- \_\_\_\_\_ I have no problem rising from sitting (including low chairs, toilet seats, car seats).
- \_\_\_\_\_ It is not as easy as it should be getting up from sitting but I can do it myself.
- \_\_\_\_\_ I need a little help from someone to get up from sitting.
- \_\_\_\_\_ I need much help from someone else to get up from sitting.
- \_\_\_\_\_ I have pain getting up from sitting.

### SECTION # 3 DRESSING AND BATHING

- \_\_\_\_\_ I can bathe and dress myself without any difficulty.
- \_\_\_\_\_ I can bathe and dress myself but it takes more time than it should.
- \_\_\_\_\_ I need some help but do most of the dressing and bathing myself.
- \_\_\_\_\_ I need much help to bathe and dress.
- \_\_\_\_\_ I am unable to help with my dressing and bathing.

### SECTION # 4 WALKING

- \_\_\_\_\_ I can walk briskly as far as I want to go without an assistive device (e.g. cane, walker, help of another)
- \_\_\_\_\_ I can walk slowly almost any distance I need to without any assistance.
- \_\_\_\_\_ I can walk about a block before I have a problem but much slower than I should be.
- \_\_\_\_\_ I can walk around outside if I am careful.
- \_\_\_\_\_ I can walk within my home without a problem, but walking outside is limited.
- \_\_\_\_\_ I have problems walking in my house.
- \_\_\_\_\_ I am afraid of falling.

### SECTION # 5 STEPS

- \_\_\_\_\_ I can walk up and down a flight of stairs without limitations.
- \_\_\_\_\_ I can walk up and down a flight of stairs but it is a little difficult for me or causes me some pain.
- \_\_\_\_\_ I can walk up and down a flight of stairs but it is very difficult.
- \_\_\_\_\_ I can walk up and down a few steps but no more.
- \_\_\_\_\_ I have some difficulty stepping up and down curbs.
- \_\_\_\_\_ I am fearful of falling on steps and curbs and need help.

**SECTION # 6 LIFTING OR CARRYING**

- \_\_\_\_\_ I can lift and carry all the items I need to without a problem.
- \_\_\_\_\_ I have some trouble carrying and lifting some items.
- \_\_\_\_\_ I can lift and carry only very light objects.
- \_\_\_\_\_ I have pain with lifting or carrying objects.

**SECTION #7 KNEELING AND SQUATTING**

- \_\_\_\_\_ I have no problem getting up off of the floor.
- \_\_\_\_\_ I could get up from the floor only if I had something nearby to pull myself up with.
- \_\_\_\_\_ I could kneel on the floor and get up without a problem.
- \_\_\_\_\_ I can squat down to pick something up off of the floor without a problem.
- \_\_\_\_\_ I could pick something up from the floor only with a great deal of difficulty.
- \_\_\_\_\_ I can not pick objects up off of the floor.

**SECTION #8 TRAVELING**

- \_\_\_\_\_ I can get in/out of cars and drive as long as I need to without any problem.
- \_\_\_\_\_ I can get in/out of cars without difficulty but can only drive limited distances.
- \_\_\_\_\_ I have some difficulty getting in/out of cars but I do it myself.
- \_\_\_\_\_ I need a little help to get in/out of cars.
- \_\_\_\_\_ I need a great deal of help to get in/out of cars.

**SECTION #9 RECREATION AND SOCIAL ACTIVITIES**

- \_\_\_\_\_ I am able to engage in all of my recreational and social activities without limitations.
- \_\_\_\_\_ I am able to engage in my recreational and social activities with a few limitations.
- \_\_\_\_\_ My limitations restrict me from my energetic recreational and social activities.
- \_\_\_\_\_ My limitations restrict me from recreational and social activities and I do not go out often
- \_\_\_\_\_ I cannot do any recreational or social activities due to my problems.

**SECTION #10 DOMESTIC AND JOB ACTIVITIES**

- \_\_\_\_\_ I can do as much work as I want.
- \_\_\_\_\_ I can do most of my usual work (in and out of the home), but not all.
- \_\_\_\_\_ My work in and out of home had had to be modified.
- \_\_\_\_\_ I need help with household chores.
- \_\_\_\_\_ I am unable to do any work at this time.

PLEASE LIST BELOW THOSE ACTIVITIES THAT YOU MOST WISH TO SEE IMPROVE:

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## Financial Policy

Thank you for choosing Water Works Total Rehab. We provide our patients with high quality one-on-one care. We want to make sure you are aware of our guidelines. This will also allow you the opportunity to ask questions prior to treatment.

### **Cancellations, No Shows, Habitual Lateness \_\_\_\_\_Initials**

Cancellations, No Shows, and Habitual Lateness compromise the timely care that our patients require. Broken appointments make it difficult to reschedule you within your allowed plan of care time frame. In addition it prevents other patients who are waiting to get an appointment to plan with such short notice. **In the event that you need to reschedule your appointment, we require 24 hours notice. If 24 hours notice is not given you may be assessed a \$25.00 fee, due and collected at your next appointment.** This fee also applies to habitual lateness.

### **Insurance and / or Medicare Guidelines \_\_\_\_\_Initials**

Verification and billing of your insurance is a courtesy we offer to our patients. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Obtaining verification of your insurance benefits is not a guarantee of payment. **You are ultimately responsible for any balance on your account.** Water Works accepts Medicare assignment, which pays 80% of your covered charges. We will bill your secondary or supplemental insurance for services rendered. If secondary or supplemental insurance does not cover any or part of you 20% co insurance, we will bill you for any outstanding balance.

### **Past Due Balances \_\_\_\_\_Initials**

We make every effort to work with our patients when there is a balance remaining after your insurance company has paid. However, past due balances will be handled thusly: **Accounts 90 days past due will be assessed 1½ % interest per month, and will be assigned to a collection agency.** In the event, you will be responsible for all interest, collection and legal fees, which may exceed the outstanding balance by up to 50%.

### **Returned Checks \_\_\_\_\_Initials**

For checks returned to us as unpaid by your bank, **you will be assessed a \$25.00 fee.**

**I have read the Financial Policy. I understand and agree to the guidelines outlined above.**

\_\_\_\_\_  
Patient's Signature or Authorized Representative

\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT REGARDING PRIVACY NOTICE**

I have been presented with a copy of the **Notice of Health Information Practices**, detailing how my information may be used and disclosed as permitted by Federal and State law. I understand the contents and terms set forth by Water Works Total Rehab in accordance with HIPAA guidelines. I request the following restriction(s) concerning the use of my personal medical information: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_ / \_\_\_ / \_\_\_ .

(Signature of Patient or authorized representative and relationship)

**CONSENT FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize any agent / employee of Water Works Total Rehab to release any medical record information that may assist in the payment of my account, or as required by law, or to other medical parties. Related information could include, but is not limited to, diagnosis, treatment, or referral.

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_ / \_\_\_ / \_\_\_ .

(Signature of Patient or authorized representative and relationship)

If patient refuses to sign this consent, please indicate your attempt to obtain a signature below.

Employee Signature: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for non-compliance: \_\_\_\_\_

**PHOTOGRAPHY AND AUTHORIZATION RELEASE**

I hereby give my consent to Water Works Total Rehab and staff members to photograph myself for medical record purposes. I understand that Water Works Total Rehab shall be the owner of all such photographs. The agency will not use items for activities beyond those listed above without further written authorization. **Initial** \_\_\_\_\_

**DISPLAYING OF SCHEDULE**

I hereby give my consent to Water Works Total Rehab to display my name on the scheduling board, which is displayed on the pool deck. I understand that other patients who are also being treated on the same day may see my name. I also understand that my name may be seen on the "Sign In" sheet by other patients who are being treated on that day. **Initial** \_\_\_\_\_

**CONSENT FOR TREATMENT**

I personally, or through my physician, request outpatient rehabilitation services by Water Works Total Rehab which may include Physical Therapy. I do hereby consent to such treatment by Water Works Total Rehab as is reasonably prescribed by my physician or as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability of such treatment except in acts of negligence.

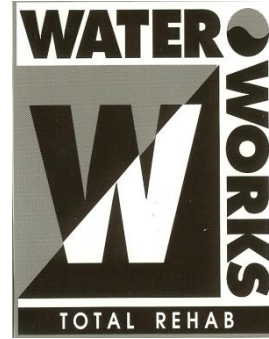
**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_ / \_\_\_ / \_\_\_ .

(Signature of Patient or authorized representative and relationship)

Witnessed By: \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_ .

Water Works Total Rehab  
999 Trail Terrace Drive  
Naples, Florida 34103  
239-649-2222 Fax 239-649-0522

[waterworksrehab@aol.com](mailto:waterworksrehab@aol.com)



I request that payment of authorized Medicare benefits be made to Water Works Total Rehab for any services I receive while under Physical Therapy care at Water Works Total Rehab. I authorize any holder of medical information concerning myself to release such information to the Health Care Financing Administration and its agents to determine these benefits payable for related services.

In Medicare assigned cases, Water Works Total Rehab agrees to accept the allowable amount, I am responsible only for the deductible, coinsurance, and non-covered services.

On my behalf, I request that Water Works Total Rehab should be reimbursed for authorized MEDIGAP benefits for provided services. I hereby authorize any holder of medical information concerning myself, to release information needed for determination of these benefits or the benefits payable for related services.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Name of Beneficiary

\_\_\_\_\_  
Health Insurance Claim

I understand that Medicare will not cover my physical therapy if I am living in a skilled nursing facility, if I have not been discharged from Home Health Services, or if I am also receiving therapy at another facility.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date