

**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 _____

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# _____

2nd 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:

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 ____ / ____ / ____ .