Office Use Only

Past Patient: ☐ Yes ☐ No | Patient Account # _____ Center: _____

Intake Completed by: | Registered by: | Verified DL / Photo ID ☐ Yes ☐ No

Patient Information

Patient Last Name: | First Name: | Middle Initial: | Date of Birth (mm-dd-yyyy):

SS #:

Status:
☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Separated ☐ Unknown

Race/Ethnicity:
☐ White ☐ African American
☐ Hispanic/Latino ☐ Asian/Pacific Islander
☐ American Indian/Alaska Native ☐ Multiracial
☐ Declined ☐ Unavailable

Sex: ☐ Male ☐ Female ☐ Non-Binary/Third Gender ☐ Prefer Not to Say ☐ Self Describe:

Preferred Pronouns:

Address: | City: | State: | Zip:

Home Phone: | Mobile Phone: | Email:

Appointment reminder contact Method: ☐ Text ☐ Mobile ☐ Email ☐ Home ☐ No appointment reminder

Employer Information

Employer Name: | Employer Phone #: | Employment Status: ☐ FT ☐ PT ☐ Self-Employed ☐ Retired ☐ Student

Address: | City | State: | Zip Code:

Emergency Contact Information

Contact Name: | Phone #: | Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Physician Information

Name of Referring Physician: | Telephone #: | Script Date:

Services ordered: ☐ PT ☐ OT ☐ ST
Date of Injury / Onset Date:

Post-Surgical ☐ Yes ☐ No
Surgery Date:

Body Part:

Were you ever treated for Outpatient Therapy before? ☐ Yes ☐ No

How did you hear about us?

Primary Insurance Information

Name of Insurance Company: | Policy or Claim #: | Group #: | Insurance Company Telephone #:

Policy Holder Name: | Policy Holder Date of Birth: | Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Information (Backup if Auto, Workers Comp. or Litigation)

Name of Insurance Company or Attorney: | Policy or Claim #: | Group #: | Insurance Company or Attorney Telephone #:

Policy Holder Name: | Policy Holder Date of Birth: | Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Additional Questions

Work Related: ☐ Y ☐ N

Adjuster name & phone #:

If WC, was accident with present employer ☐ Y ☐ N
If no, who was employer? _____
Occupation: _____

Auto Related: ☐ Yes – State: _____ ☐ No

Date of Auto of Accident: ____ / ____ / ____
Type of Accident: Driver / Passenger / Pedestrian / Job / Fall / Other

Medicare Only

Do you have Medicare? ☐ Y ☐ N **Are you currently receiving Home Health Services?** ☐ **Y** ☐ **N**
If Yes, name of agency & what type of Home Health Services are you receiving? _____
If No, have you received services in past 60 days? ☐ Y ☐ N If yes, name of agency & last date of service _____
Are you currently residing in a Skilled Nursing Facility? If yes, Name of Facility? _____
If Yes, are you on/in the "Medicare Unit"? ☐ Y ☐ N

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

Kessler REHABILITATION CENTER
Select Medical

Rev 6/20

Outpatient Medical History / Screening Form

To be completed by the patient

Patient Name:_____ DOB: _____ Age:_____ Height:_____ Weight: _____

Why are you here?_____ Date of Injury:_____

Spoken Languages: _____

Preferred language to receive healthcare information *for patient* :_____

Preferred language to receive healthcare information *for legal guardian / Healthcare Proxy* : _____

Family Physician/Internist:_____ Telephone # :_____

Religious / Cultural Needs: NO ☐ YES ☐ Please Explain:_____

Special Learning Needs: NO ☐ YES ☐ Please Explain:_____

Hearing Difficulty: NO ☐ YES ☐

Speaking / Communication Difficulty: NO ☐ YES ☐

Medical Information:

History of	YES	NO	Family History	Y	N
Diabetes	☐	☐		☐	☐
Hypertension (high blood pressure)	☐	☐		☐	☐
Heart Attack	☐	☐		☐	☐
Heart Disease	☐	☐		☐	☐
High Cholesterol	☐	☐		☐	☐
Smoking	☐	☐			
Chest Pain / Angina	☐	☐			
Light-Headedness / Dizziness / Fainting	☐	☐			
Hypotension (low blood pressure)	☐	☐			
Shortness of Breath	☐	☐			
Ankle Swelling	☐	☐			
Night Coughing	☐	☐			
Cancer / Tumors / Growths	☐	☐		☐	☐
Radiation / Chemotherapy Treatment	☐	☐			
Osteoporosis	☐	☐		☐	☐
Osteoarthritis	☐	☐		☐	☐
Rheumatoid Arthritis	☐	☐		☐	☐
Rheumatic Disease	☐	☐		☐	☐
Have you had / have a: Stroke	☐	☐		☐	☐
Multiple Sclerosis	☐	☐		☐	☐
Brain Injury	☐	☐			
Spinal Cord Injury	☐	☐			
Fractures / Total Joint Replacement	☐	☐			

DATE:_____ AREA:_____

DATE:_____ AREA:_____

	YES	NO
Diminished Sensation / Numbness	☐	☐
Skin Sensitivities:	☐	☐
Latex ☐ / Adhesives ☐ / Temperature ☐		
History of pressure sores	☐	☐
Pacemaker / Defibrillator	☐	☐
Bleeding / Bruising (recent history)	☐	☐
Hypoglycemia	☐	☐
Active seizure disorder	☐	☐
Dementia / Alzheimer's	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
* Always have inhaler with you	☐	☐
Lung Disease / Emphysema / COPD	☐	☐
* Oxygen use	☐	☐
Are You Pregnant?	☐	☐
COVID-19? Date:		
In the past month, have you frequently been bothered by feeling down, depressed or hopeless?	☐	☐
In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things?	☐	☐
Other: _____	☐	☐
Depression / Anxiety / Panic Attacks		

In the past three months have you experienced:

Changes or difficulty with Bowel	☐	☐
Changes or difficulty with Bladder	☐	☐
Night Sweats	☐	☐
Fever	☐	☐

Are you in pain?

Location of pain_____

If you answered yes to any of the above:

	YES	NO
Are you under the care of an MD for these conditions?	☐	☐

Allergies: _____

_____

Surgery(s) within last 3 months - Include Dates: _____

What are your Rehabilitation goals?:_____

Advanced Directives: If you need information regarding Advanced Directives, please contact the site Admission/Office Assistant. Advanced Directives are not honored in the Outpatient Setting.

FALL RISK ASSESSMENT*:	YES	NO
Have you fallen within the last year? If so, how many times? _____	☐	☐
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet or in your wheelchair?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory / cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

AS PER CMS FALL SCREENING CRITERIA

***Patient is considered a fall risk if patient has fallen two or more times in the past year**

***Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year**

NUTRITIONAL SCREENING	YES	NO
Unexplained weight loss? (>5% in last 30 days)	☐	☐
Recent loss of appetite/aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐
Have you had a decrease in food intake?(<50% for 3 days or more)	☐	☐
Are you under the care of a MD for these conditions?	☐	☐

CURRENT MEDICATION (List below)

I provided a separate list of medications: ☐

I am currently not taking any over the counter or prescribed medications / herbals: ☐

Are all meds prescribed by a physician? Yes ☐ No ☐

Please inform your therapist of any changes in medications, medical conditions or surgeries so this summary list can be updated as you progress in your treatment.

PATIENT SIGNATURE:_____**DATE:**_____

If signature other than patient, relationship to patient (guardian / parent if minor):_____

To be completed by evaluating Therapist

**FALL RISK - Patient is considered a fall risk if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgment indicates. Clinician should refer to the Fall Prevention Policy PC OP 1018.*

Patient has been identified as a fall risk:	YES ☐	NO ☐	
If Yes, fall prevention program has been implemented:	YES ☐	NO ☐	
Patient has been identified as a nutrition risk :	YES ☐	NO ☐	(If yes, notify MD)
Patient would benefit from a Social Services referral:	YES ☐	NO ☐	yes if therapist feels patient life is threatened, or if patient is a threat to others)

Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**

UPDATES:

Please list changes to Medication:

Please list changes to medical condition/surgeries:

PATIENT SIGNATURE:_____**DATE:**_____

THERAPIST SIGNATURE: _____ **DATE:**_____

Medical Screening Form (Optional)

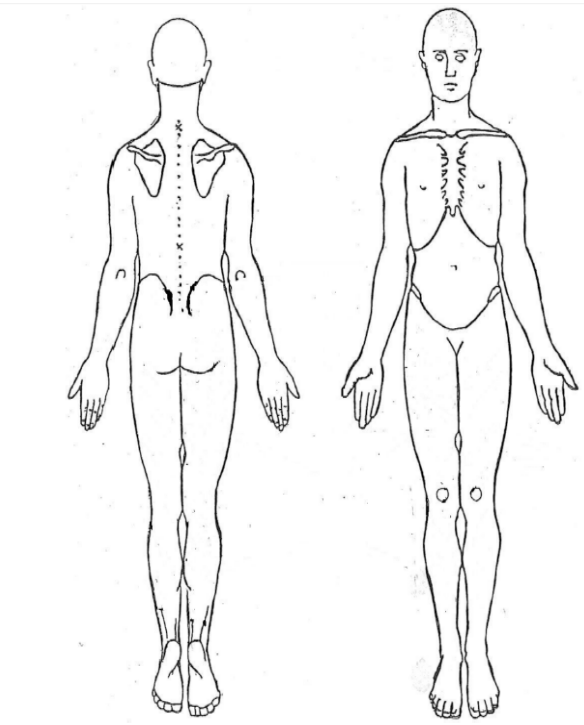
Name:_____ Date:_____

I HAVE PAIN: YES_____ NO_____ (If no skip to "Patient Specific Functional Scale" below)

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = oooooo Stabbing = //////////
Burning = XXXXXX Deep Ache = ZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain or symptom on the following line:

Select One Select One Select One

0 1 2 3 4 5 6 7 8 9 10

(**0** = none →**10** = worst imaginable. Indicate level for each with B, C, and W)

1. What makes your pain or symptom worse?

_____

_____

2. What makes your pain or symptom better?

_____

_____

3. Are your symptoms: (check one)
☐Getting worse; ☐The same; ☐Improving

4. How are you able to sleep at night? (check one)
☐Fine; ☐Moderate Difficulty ; ☐Only with Medication

5. Do you have pain at night? ☐Yes … ☐ No

6. When (date) did your problem begin? _____

Have you been treated for this before? ☐Yes … ☐No

When? _____

How? _____

PATIENT SPECIFIC FUNCTIONAL SCALE :

(*First Time Use for This Case)* Identify up to three (3) important activities that you are unable to do or are having difficulty with as a result of your medical condition. Using the Scale below indicate your ability to perform these activities today.

(***0** = unable to perform →**10** = as able as pre-injury)*

1. Activity_____ Select One 0 1 2 3 4 5 6 7 8 9 10

2. Activity_____ Select One 0 1 2 3 4 5 6 7 8 9 10

3. Activity _____ Select One 0 1 2 3 4 5 6 7 8 9 10

Kessler REHABILITATION CENTER Select Medical Kessler INSTITUTE FOR REHABILITATION Select Medical

Consent to Treatment; Authorization to Release Information; and Statement of Financial Responsibility

Revised 08/01/2018

Patient Name:_____ **Date**:_____ **Acct#**:_____

Kessler Institute for Rehabilitation appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or you may access our on-line bill payment option @ https://pay.instamed.com/kesslerbillpay once a statement is received from the billing office, or by calling our customer service department at 1-866-889-9968.

I have read the above policy regarding my financial responsibility to Kessler Institute for Rehabilitation for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Kessler Institute for Rehabilitation. I agree to pay Kessler Institute for Rehabilitation the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. *Patient Service Specialist Initials:* _____

Signature:_____(relationship to patient: self – guardian – other**:**_____) **Date:**_____

You agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and use of automatic dialing devices, as applicable.

Signature:_____(relationship to patient: self – guardian – other**:**_____) **Date:**_____

You will receive calls and/or text messages that deliver autodialed or pre-recorded telemarketing messages from an automatic telephone dialing system. You consent to receive such calls and/or texts at the telephone number associated with your account. Your consent to receive such calls and/or text messages is not a condition of any purchase of a service or product.

I/We have read this disclosure and agree that Provider, and/or their representative, may contact me/us as described above.

Signature:_____(relationship to patient: self – guardian – other:_____) **Date:**_____

I acknowledge that the Notice of Privacy Practices and Notice for Federal Civil Rights is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:**_____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I am aware of my diagnosis and voluntarily consent to have Kessler Institute for Rehabilitation, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical, speech, and occupational therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Kessler Institute for Rehabilitation is limited to physical, speech, and/or occupational therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:** _____

I further authorize Kessler Institute for Rehabilitation to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:**_____

RESEARCH: Research to improve patient care is conducted at Kessler and is approved and monitored by the Kessler Foundation Institutional Review Board or another certified and Kessler-approved Institutional Review Board (collectively, "IRB"). This review and monitoring assures strict confidentiality with regard to who may view medical records. I consent to the use of information in my record for research purposes. I understand that I will not participate in any experimental treatment or protocol without my express, prior written consent that has been reviewed and approved by an IRB, as defined above.

☐ I consent to allow a member of the Kessler Foundation contact me regarding my voluntary participation in current or future research studies.

☐ I do not consent to allow a member of the Kessler Foundation to contact me regarding my voluntary participation in current or future research studies.

Kessler Inpatient Rehabilitation provides our patients' mailing information to the Kessler Foundation for them to use in fundraising communications. If you do not want us to share your information with the Kessler Foundation or do not want to receive future fundraising communications, please check this box. ☐ There is no requirement that you agree to accept fundraising communication from us, and we will honor your request not to receive any more fundraising communications after the date we receive your decision. Your treatment or payment will not be affected by your choice to opt-out of a fundraising communication.

Signature: _____ Date: _____

(Relationship to patient: self - - guardian - - other: _____)