HackensackUMC Mountainside

Outpatient Rehabilitation Department
Medical History Form

Name: ________________ Birth Date: ________________
Referring Doctor: ________________ Primary Care Physician: ________________
Phone Number: Home ____________ Email: ________________________________
Cell ______________

Reason you are attending therapy: ____

Please check any of the following whose care you have been under (past year):

________Medical Doctor (MD) ________ Psychiatrist/Psychologist
________Orthopedic Doctor ________ Physical Therapy
________Dentist ________ Chiropractor
________Other (Explain) ____

Why have you seen the above? In addition, include any emergency room trips and prior hospitalizations. Fill in dates and Explanation below.

____
____
____

If you have a history of any of the following, please indicate below:

☐ Cancer: What type?	☐ Lymes Disease
☐ Heart Problems	☐ Rheumatoid Arthritis
☐ Pacemaker	☐ Osteoarthritis
☐ High Blood Pressure	☐ Fibromyalgia Syndrome(FMS)
☐ Diabetes	☐ Depression
☐ DVT/blood clots	☐ Thyroid Problems
☐ Circulation problem	☐ Joint Replacement
☐ Osteoporosis	☐ Multiple Sclerosis
☐ Asthma	☐ Seizures
☐ Emphysema/Bronchitis	☐ Epilepsy
☐ Tuberculosis	☐ Stroke
☐ Kidney Disease	☐ Alcoholism, Illicit Drug Use
☐ HIV Disease/AIDS	☐ Hepatitis
☐ Latex Allergy	☐ Gout
☐ Other Allergies: Explain	☐ Other: Explain

During the past month, have you been feeling down, depressed or hopeless? YES NO
During the past month, have you had little interest in doing things? YES NO
Do you feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO
Date of last menstrual period: ________________

Please Describe any significant injuries for which you have been treated (including fractures, sprains, etc. and the approximate date off injury.

Date	Injury	Date	Injury

Which of the following OVER-THE-COUNTER medication have you taken in the past week?

Yes	No	Aspirin
Yes	No	Tylenol
Yes	No	Advil/Motrin/Ibuprofen
Yes	No	Laxatives
Yes	No	Decongestant
Yes	No	Antihistamines
Yes	No	Antacid
Yes	No	Vitamins/Mineral supplement
Yes	No	Other

Please list any PRESCRIPTION medication you are currently taking (INCLUDING tablets, capsules, patches, and/or injections).

1. ___________________ 2. ___________________ 3. ___________________
4. ___________________ 5. ___________________ 6. ___________________
7. ___________________ 8. ___________________ 9. ___________________

How many caffeinated coffee or caffeine containing beverages do you drink per day? ______
Do you smoke? Yes ____ No ____
If you do smoke, how many cigarettes do you smoke a day? __________
How many days per week do you drink alcohol? _________
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ___

Have you recently noted:

Yes	No	Unexplained weight loss or weight gain
Yes	No	Nausea/Vomiting
Yes	No	Fatigue
Yes	No	Weakness
Yes	No	Fever/chills/sweats
Yes	No	Numbness/tingling
Yes	No	Dizziness when you stand up
Yes	No	Chest pain
Yes	No	Shortness of breath

Patient signature____ Date____________

Therapist Signature ____ Date____________

Hackensack UMC Mountainside

1 Bay Avenue
Montclair, NJ 07042

Welcome to the Rehabilitation Department at Hackensack UMC Mountainside. Our highly qualified and motivated staff is here to make your rehabilitation experience beneficial as well as enjoyable. To ensure this, we are providing some simple guidelines to follow:

- Please double check with your insurance company to make sure that we do participate with your plan. Ultimately, you are responsible for any financial obligations that are associated with your insurance.
- If your insurance requires a pre-certification there may be delay in your follow up visit. The rehabilitation department will notify you when the authorization is received.
- If you have a Co-payment, it is required prior to services being rendered.
- If you accumulate three no shows or cancelled appointments you will may discharged for the services you are receiving at the Outpatient Department of Hackensack UMC Mountainside. You will not be permitted to schedule future appointment at this facility without written consent from the Director of Rehabilitation Services.
- Please be prompt with your scheduled appointment so we can maximize your treatment. If you are arriving late, your treatment time is subject to cancellation and rescheduling.
- Please bring or wear proper clothing to make you affected treatment area accessible. We do provide changing rooms with lockers for you convenience.(Please bring your own lock)
- In case of inclement weather, please call ahead of time to confirm your appointment.
- Use of cellular phones is prohibited inside the gym area. Please turn off your cellular phone when you are inside of the gym.
- Anyone who is under the age of 18 in the reception/waiting area unattended. Please make arrangement for your children before coming to Physical Therapy.
- Most importantly, please communicate with your therapist! The more information that is known the better we can help you recover.

By following these simple guidelines, together we can reach your goal in the shortest amount of time.
Thank you again for choosing us as your rehabilitation provider.

Please sign to acknowledge that you have read and understood the guidelines.

_______________________________________ ______________
Patient Signature Date

_______________________________________ ______________
Signature of legal Guardian-Health Care Agent, or other personal Representative Date

_______________________________________ ______________
Witness Signature Date

Hackensack UMC Mountainside
1 Bay Avenue
Montclair, NJ 07042

Insurance Authorization/Pre-certification information

Welcome to the Rehabilitation Department at Hackensack UMC Mountainside. Our staff will make every effort to work with you and your insurance company. However, the following conditions apply:

- Please be advised that some insurance companies require pre-certification/ authorization before starting any physical therapy treatment
- Please follow up with your insurance company to confirm whether you are required to obtain a pre-certification/ authorization
- Please inform your insurance company that all authorizations must be faxed to the Hackensack UMC Mountainside Rehabilitation Department at the following fax number 973-680-7917
- The authorization should include the amount of visits approved by your insurance company and the date span for the visits along with an authorization number
- Pre-certification/ authorization may delay your follow up appointment. To avoid a longer waiting period please contact your insurance company to expedite approval
- After your initial evaluation a member of our staff will fax the appropriate documentation to your insurance company for approval
- You are ultimately responsible for the follow up and ensure that authorization has been granted before starting treatments
- Failure to obtain an authorization from your insurance company will result in you being personally responsible for any financial obligations that are associated with your treatments

By following these guidelines and working together we hope to ensure a positive experience at Hackensack UMC Mountainside. Thank you again for choosing us as your rehabilitation provider!

______________________________________ ______________
Patient Signature Date

______________________________________ ______________
Signature of legal Guardian-Health Date
Care Agent, or other personal Representative

______________________________________ ______________
Witness Signature Date

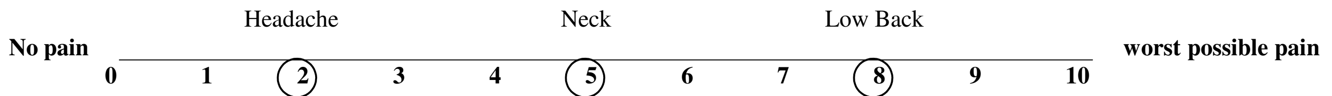
QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: ____ Date: ____________________

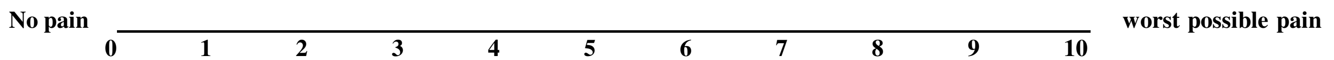
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

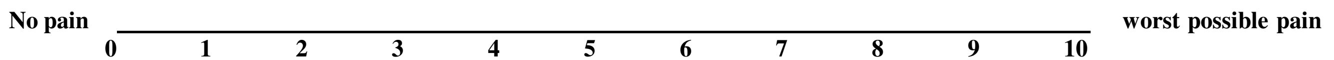
Example:



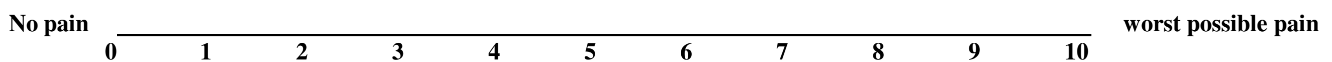
1 – What is your pain RIGHT NOW?



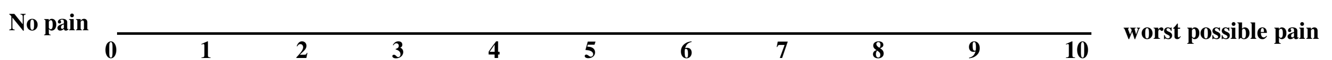
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

____

____

____

______________________________ Patient’s Signature

______________________________ Examiner’s Signature

The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
2	Your usual hobbies, recreational or sporting activities.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
3	Getting into or out of the bath.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
4	Walking between rooms.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
5	Putting on your shoes or socks.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
6	Squatting.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
7	Lifting an object, like a bag of groceries from the floor.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
8	Performing light activities around your home.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
9	Performing heavy activities around your home.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
10	Getting into or out of a car.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
11	Walking 2 blocks.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
12	Walking a mile.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
13	Going up or down 10 stairs (about 1 flight of stairs).	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
14	Standing for 1 hour.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
15	Sitting for 1 hour.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
16	Running on even ground.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
17	Running on uneven ground.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
18	Making sharp turns while running fast.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
19	Hopping.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
20	Rolling over in bed.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80 (fill in the blank with the sum of your responses)**

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

ESCALA FUNCIONAL DE LA EXTREMIDAD INFERIOR

Estamos interesados en saber si esta teniendo alguna dificultad al realizar las actividades enumeradas a continuación debido al problema en su pierna.
Por favor de una respuesta por **cada una** de las actividades.

En el dia de hoy, tiene o tendría alguna dificultad realizando alguna de las siguientes actividades:

	Actividades	Dificultad extrema o incapaz de realizar la actividad	Mucha dificultad	Dificultad Moderada	Un poco de Dificultad	Ninguna Dificultad
1	Alguna parte de su trabajo habitual, quehaceres domésticos, o actividades escolares.	0	1	2	3	4
2	Sus pasatiempos usuales, actividades recreativas o deportivas.	0	1	2	3	4
3	Entrando o saliendo de la tina.	0	1	2	3	4
4	Caminando de una habitación a otra.	0	1	2	3	4
5	Poniéndose los zapatos o medias.	0	1	2	3	4
6	Poniéndose en cuclillas.	0	1	2	3	4
7	Levantando un objeto, por ejemplo, una bolsa de compras de supermercado del piso.	0	1	2	3	4
8	Realizando actividades ligeras en su casa.	0	1	2	3	4
9	Realizando actividades pesadas en su casa.	0	1	2	3	4
10	Subiéndose o bajándose de un carro.	0	1	2	3	4
11	Caminando dos cuadras.	0	1	2	3	4
12	Caminando una milla.	0	1	2	3	4
13	Subiendo o bajando 10 peldaños de una escalera.	0	1	2	3	4
14	Estando parado por una hora.	0	1	2	3	4
15	Estando sentado por una hora.	0	1	2	3	4
16	Corriendo sobre terreno plano.	0	1	2	3	4
17	Corriendo sobre terreno irregular.	0	1	2	3	4
18	Haciendo vueltas agudas mientras corre rápidamente.	0	1	2	3	4
19	Saltando.	0	1	2	3	4
20	Volteandose en la cama.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence):9 points

SCORE: _______ /80
Please submit the sum of responses to ACN Group.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.