



Memorial Rehabilitation and Occupational Medicine

302 S. 10th Ave., Yakima, WA 98902
Phone # 509-574-3300 Fax # 509-574-3315



Welcome to the Springs, Memorial Rehabilitation and Occupational Medicine and thank you for choosing us for your rehabilitation! We look forward to working with you to improve your quality of life and are excited to begin your care!

INITIAL CONSULTATION: Your initial consultation has been scheduled for _____ at _____. It is essential that you complete and bring this packet to your scheduled appointment. ***Please make sure this packet is complete prior to the start time of your scheduled appointment.***

CLINIC HOURS: Monday-Friday, 7:00 am to 6:00 pm. Our phone is on 24-hours/day, 7-days/week so please leave a message anytime. Please update the front desk if there are any changes in your daytime/cell phone numbers or insurance information. If we need to contact you, we use the information in our system. Good communication will prevent unnecessary traveling and billing complications.

ATTENDANCE POLICY: In order to get the maximum benefit of our services, please attend all your scheduled appointments and come on time and ready to go.

Cancellations: If you are unable to attend a scheduled appointment, please notify our clinic 24 hours in advance at (509) 574-3300. Please notify us immediately if you are ill.

No-Shows: If you miss a scheduled appointment and you did not cancel, it is called a No-Show.

Late Arrivals: If you arrive 10 mins. past your scheduled appointment time, your appointment may need to be rescheduled. Please notify our clinic by calling (509) 574-3300 if you are running late.

All Cancellations and No-Shows will be documented in your medical record and appropriately reported to your provider. **If you accumulate cancellations and/or no-shows, your provider/therapist may discharge you.**

INSURANCE CO-PAYS: As a courtesy, The Springs will file all claims to your insurance carriers for services provided. Co-pays will need to be paid at the time of your appointment. We will also need a picture ID and copy of your insurance card(s) each month.

IMPORTANT: Although we do our best to confirm your insurance eligibility, please check with your insurance company to verify coverage of therapy services so you don't receive an unexpected bill. They will verify that you are covered and the number of visits you are allowed.

Please speak with your provider/therapist if you have any questions about the information on this form. By signing below, you understand the attendance policy and understand the risk of missing appointments or failure to check with your insurance company. A copy of this form will be provided to you upon request.

THANK YOU for choosing to work with us!

Patient Signature

Date

Print Name

MEDICAL PROFILE QUESTIONNAIRE

WHAT BRINGS YOU TO OUR CLINIC TODAY? Please describe your complaints _____

Date of onset: _____ Date of surgery: _____

How long have symptoms been present? _____

For women: Are you pregnant? Yes No If yes, due date: _____

Are your symptoms due to an injury? Yes No If yes, check the appropriate box: Work Related Injury
 Motor Vehicle Accident Sports No Injury/incident Other _____

If not due to an injury, what do you think is causing your symptoms? _____

Who referred you here? Name _____ Phone #: _____

Family Physician: _____ Phone#: _____

WORK RELATED INJURY: Date of Injury _____ Claim #: _____ Date last worked _____

Employer at time of injury _____

Length of time with employer: ____ mos. / ____ years

Describe how the injury / accident happened: _____

Any prior or current L&I claims: Yes No If yes, please list: _____

WHAT ARE YOUR PERSONAL GOALS? Check any that apply.

To relieve/reduce pain Improve sleep Return to usual work activities
 Resume household chores Resume yard work Resume recreational/leisure activity
 Regain mobility/increase flexibility and strength Other _____

Pain / symptoms worse in: Morning Mid-day Evening Night

Pain / symptoms least in: Morning Mid-day Evening Night

Does it keep you awake? Yes No

Does it wake you up? Yes No

Describe your sleeping position: _____

Do symptoms prevent you from sleeping in your normal position? Yes No If yes, please explain: _____

Currently sleeping 2 3 4 5 6 7 8 hours/night vs. usually ____ hours/night.

Do you take part in regular physical activity/exercise Yes No If yes, please list type and frequency:
_____ time(s) per day / week If no, please explain _____

What activities increase your symptoms (i.e. sit, lay, stand, rest, activity, walk, etc.)? _____

What decreases your symptoms: (i.e. ice, heat, rest, change position, walk, medication, etc.)? _____

Have you had therapy for this current problem? Yes No Occupational Physical Massage

If yes, did it help relieve your symptoms/improve your condition? Yes No Please explain: _____

List any other treatment you have had for this current problem _____

Have you had any previous episodes with similar symptoms? Yes No If yes, when? _____

List your LEISURE activities affected by your current problem _____

TEST RESULTS for this current problem: (Imaging, X-Ray, MRI, CT – specify by name and dates of studies and results if known): _____

Do you smoke or Yes No If yes, how much? ____ packs / day / week

Do use other tobacco products? Yes No If yes, what kind and how much? _____

SUMMARY OF CARE

PATIENT please complete all sections that apply.

Chronic Illnesses / Conditions	Date of Onset	Current Pain Medications	Dosage
Hospitalization/Surgeries	Date	Routine Medications	Dosage
Orthopedic Injuries: List Sprains, Fractures, Dislocations, etc. and Body Part(s)	Date	Over-the-Counter Medications	Dosage
Allergies: (Meds., Latex, Skin, Food, etc.)		Vitamins/Minerals/Herbs:	Dosage
MISCELLANEOUS:			

If there is no pain, please check here and proceed to the next page.

Please indicate where your pain is in the diagram by using the symbols below:

Numbness _____

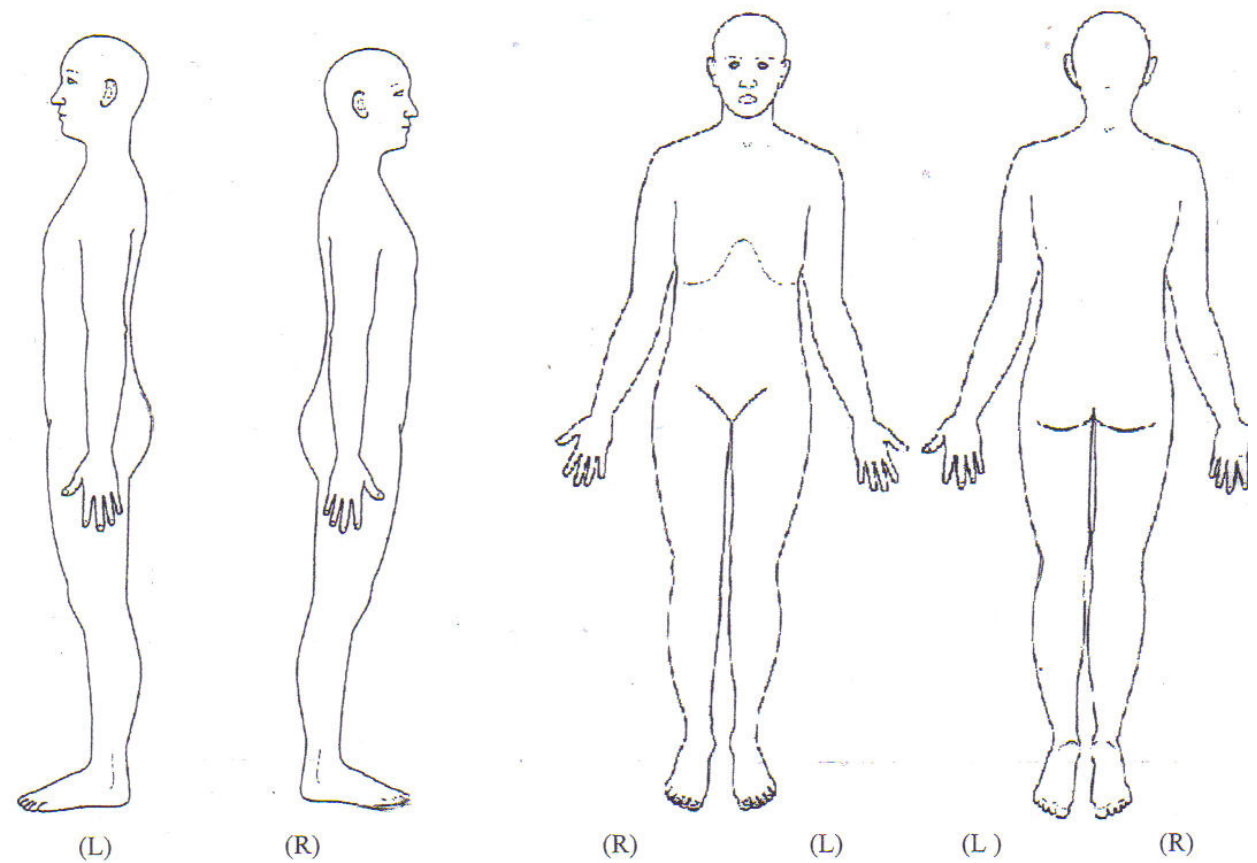
Burning XXXX

Stabbing /////

Pins and Needles oooo

Dull Ache

Other **** List _____



PAIN LEVEL

0	1	2	3	4	5	6	7	8	9	10
No Pain	Just Noticeable	Mild Annoying Nagging	Uncomfortable	Distressing Miserable	Intense	Horrible Dreadful	Unbearable Excruciating			

“0” represents no pain and “10” represents unbearable pain, please rate your pain by circling the appropriate number when your pain is:

AT ITS WORST 0 1 2 3 4 5 6 7 8 9 10

AT ITS BEST 0 1 2 3 4 5 6 7 8 9 10

MOST OF THE TIME 0 1 2 3 4 5 6 7 8 9 10

Patient Signature

Date

Therapist Signature

Patient's Pain Goal:

My Falls-Free Plan

As we grow older, gradual health changes and some medications can cause falls, but many falls can be prevented. Use this to learn what to do to stay active, independent, and falls-free.

Check "Yes" if you experience this (even if only sometimes)	No	Yes	What to do if you checked "Yes"
Have you had any falls in the last six months?			<input type="checkbox"/> Talk with your doctor(s) about your falls and/or concerns. <input type="checkbox"/> Show this checklist to your doctor(s) to help understand and treat your risks, and protect yourself from falls.
Do you take four or more prescription or over-the-counter medications daily?			<input type="checkbox"/> Review your medications with your doctor(s) and your pharmacist at each visit, and with each new prescription. <input type="checkbox"/> Ask which of your medications can cause drowsiness, dizziness, or weakness as a side effect. <input type="checkbox"/> Talk with your doctor about anything that could be a medication side effect or interaction.
Do you have any difficulty walking or standing?			<input type="checkbox"/> Tell your doctor(s) if you have any pain, aching, soreness, stiffness, weakness, swelling, or numbness in your legs or feet— don't ignore these types of health problems. <input type="checkbox"/> Tell your doctor(s) about any difficulty walking to discuss treatment. <input type="checkbox"/> Ask your doctor(s) if physical therapy or treatment by a medical specialist would be helpful to your problem.
Do you use a cane, walker, or crutches, or have to hold onto things when you walk?			<input type="checkbox"/> Ask your doctor for training from a physical therapist to learn what type of device is best for you, and how to safely use it.
Do you have to use your arms to be able to stand up from a chair?			<input type="checkbox"/> Ask your doctor for a physical therapy referral to learn exercises to strengthen your leg muscles. <input type="checkbox"/> Exercise at least two or three times a week for 30 min.
Do you ever feel unsteady on your feet, weak, or dizzy?			<input type="checkbox"/> Tell your doctor, and ask if treatment by a specialist or physical therapist would help improve your condition. <input type="checkbox"/> Review all of your medications with your doctor(s) or pharmacist if you notice any of these conditions.
Has it been more than two years since you had an eye exam?			<input type="checkbox"/> Schedule an eye exam every two years to protect your eyesight and your balance.
Has your hearing gotten worse with age, or do your family or friends say you have a hearing problem?			<input type="checkbox"/> Schedule a hearing test every two years. <input type="checkbox"/> If hearing aids are recommended, learn how to use them to help protect and restore your hearing, which helps improve and protect your balance.
Do you usually exercise less than two days a week? (for 30 minutes total each of the days you exercise)			<input type="checkbox"/> Ask your doctor(s) what types of exercise would be good for improving your strength and balance. <input type="checkbox"/> Find some activities that you enjoy and people to exercise with two or three days/week for 30 min.
Do you drink any alcohol daily?			<input type="checkbox"/> Limit your alcohol to one drink per day to avoid falls.
Do you have more than three chronic health conditions? (such as heart or lung problems, diabetes, high blood pressure, arthritis, etc. Ask your doctor(s) if you are unsure.)			<input type="checkbox"/> See your doctor(s) as often as recommended to keep your health in good condition. <input type="checkbox"/> Ask your doctor(s) what you should do to stay healthy and active with your health conditions. <input type="checkbox"/> Report any health changes that cause weakness or illness as soon as possible.

The more "Yes" answers you have, the greater your chance of having a fall. Be aware of what can cause falls, and take care of yourself to stay independent and falls-free!

Patient Signature _____ Date _____