

RESTON THERAPY AND FITNESS CENTER PATIENT REGISTRATION FORM

Referring Physician's Name: _____ Phone: _____
Primary Physician's Name: _____ Phone: _____

PERSONAL INFORMATION

Patient's Name: _____ Name you go by: _____
Address: _____
City: _____ State: _____ Zipcode: _____
Home phone: _____ Cell Phone: _____ Work: _____
Date of Birth: _____ Age: _____ SSN: _____ - _____ - _____
Sex: Male Female Marital Status: Single Married Divorced Widowed
Do you have a living will? YES NO
Have you been out of the country within the last 10 days? YES NO
Are you currently participating in a research study? YES NO

MEDICARE INFORMATION (if applicable)

What is your retirement date? _____
What is your significant other's retirement date? _____
Have you been hospitalized within the last 2 months? YES NO
If YES, which hospital? _____ (Name) _____ (City/State)
Admission date (to hospital): _____ Discharge date (from hospital) _____

NEXT OF KIN

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zipcode: _____
Home phone: _____ Cell Phone: _____ Work: _____

EMPLOYMENT INFORMATION

Are you currently working? YES NO If no, is it due to your condition? YES NO
Employer's Name: _____
Employer's Address: _____
City: _____ State: _____ Zipcode: _____
Work phone: _____ Extension: _____

INSURANCE INFORMATION

Subscriber's Name: _____ SSN: _____ - _____ - _____
Relationship to Subscriber: _____ Subscriber DOB: _____
Insurance Company: _____
Address for Billing: _____
City: _____ State: _____ Zipcode: _____
Member ID/Subscriber ID: _____ Group/Policy: _____
Insurance Phone # _____

WORKER'S COMPENSATION (IF APPLICABLE)

Date of occurrence/injury: _____
Case Manager Name & Phone: _____
Claim Number: _____

Patient Signature (or Legal Representative) (Relationship) Date



ADMIN

<p>RESTON THERAPY AND FITNESS PATIENT REGISTRATION FORM</p> <p>777.094 10/04/10 PAGE 1 OF 1</p>	<p>PATIENT LABEL</p>
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Reston Hospital Center
Reston Therapy & Fitness Center

Off Campus Medicare Outpatient Coinsurance Notice

To our Medicare patients;

Medicare regulations require us to provide you with a notice of your potential financial liability for the hospital service(s) you will receive.

Since the exact type and extent of care needed is not known, we are required to advise you that, because the service(s) are furnished by a department of Reston Hospital Center, you will incur a coinsurance liability to the hospital that you would not incur if the services were furnished in an entity that is not hospital-based.

The coinsurance liability to the hospital is in addition to any Medicare coinsurance liability for physician/professional services provided in conjunction with the hospital services.

I have read the foregoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law.

Signature of patient/authorized representative

Date



ADMIN

RESTON THERAPY AND FITNESS OFF CAMPUS COINSURANCE MEDICARE FORM	PATIENT LABEL
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OPTIMAL INSTRUMENT

CONFIDENCE BASELINE

Instructions: Please circle the level of confidence you have for each activity today.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking-short distance	1	2	3	4	5	9
11. Walking-long distance	1	2	3	4	5	9
12. Walking-outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

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Reston Therapy and Fitness OPTIMAL - Confidence Baseline	PATIENT LABEL
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PT

OPTIMAL INSTRUMENT

DIFFICULTY BASELINE

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking-short distance	1	2	3	4	5	9
11. Walking-long distance	1	2	3	4	5	9
12. Walking-outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

****Please complete all 22 items. This is an insurance requirement.****

Also, please answer the following required question:

Do you feel safe in your home environment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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PT

Outpatient Summary List

Date: _____ HT: _____ ft. _____ in WT: _____ lbs.

ALLERGIES Meds: Food: Other:

Diagnoses/Medical Conditions:

Operative/Invasive Procedures:

Source of Medication List: <i>(check all that apply)</i> <input type="checkbox"/> Patient/Family Recall <input type="checkbox"/> Patient Medication List <input type="checkbox"/> Other: <i>(Specify)</i> _____	Check Release for Reconciliation: <input type="checkbox"/> Outpatient Pre-op/Pre-Procedure Assessment <input type="checkbox"/> Outpatient Treatment
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A complete Medication List must include: Name, Dose, Route and Frequency

Name of Medication (Current, over the counter, herbal)	Dose Route Frequency	Date/Time Medication last taken	Purpose of Medication	Medication Reviewed and Acknowledged
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

Please sign below:	
Patient/Legal Representative: _____ Nurse/Tech/Therapist: _____	Date/Time: _____ Date/Time: _____



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RESTON THERAPY AND FITNESS OUTPATIENT SUMMARY LIST	Patient Label
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Pain Drawing

KEY	
//////	Pain
XXXX	Burning
0000	Pins &
====	Numbness
++++	Aching

Dominant Hand:
 Right Handed
 Left Handed

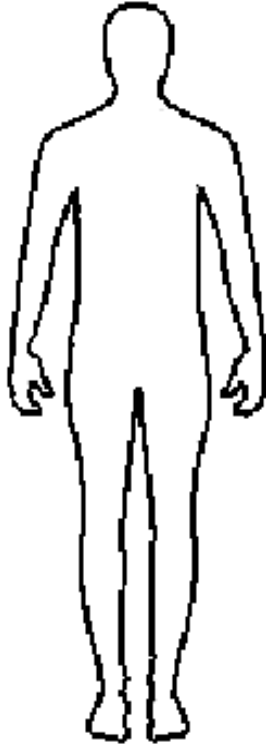
Is your pain intermittent (comes and goes) ?

Constant (24 hours)?

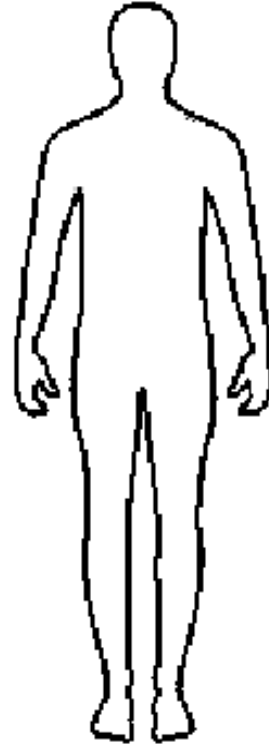
What specific activities cause pain?

Is there anything you can do to eliminate or decrease the Pain? _____

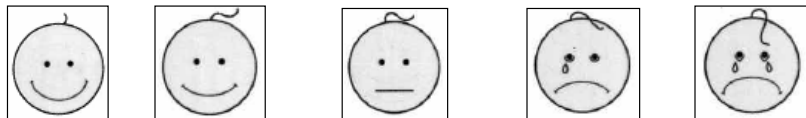
Front



Back



- | | |
|-------------------------------------------------------------------|---------------------------------------------------------------|
| 0 No pain | 5-6 Distressing pain that moderately limits activities |
| 1 Slight occasional pain | 7-9 Intensely severe pain |
| 2 Mild pain; you are aware of it but it does not limit activities | 10 Worse pain imaginable significantly limits your activities |
| 3-4 Uncomfortable pain that minimally limits activities | |



0 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR CURRENT PAIN LEVEL

Date _____

Signature: _____



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RESTON THERAPY AND FITNESS PAIN SCALE 777.013 8/31/10 PAGE 1 OF 1	PATIENT LABEL
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