Grand Valley
Rehabilitation Services
Community HOSPITAL

Welcome Packet

Thank you for choosing Grand Valley Rehabilitation Services to assist you with your current condition.

Please fill out the enclosed paperwork and bring it with you to your appointment. Important things to remember:

- You will need to bring your insurance card, a photo ID and the referral/prescription from the referring physician.
- Payment of any co-pay associated with your insurance is expected at time of service and at each visit. Our front office staff can assist you in determining your estimated liability (or payment) that will be expected at the time of your visit(s).
- Wear comfortable clothing.

NOTE: If your visit is due to an accident or workman compensation:

- Please have the claim #
- Your employer name
- Name of Insurance Company this claim is through
- The name of attorney, if any

NOTE: Grand Valley Rehabilitation Services has two locations: 2004 N. 12th Street (not at the main hospital) and 2373 G Road, Suite 130.

If you have any questions, please call (970) 644-3720 to speak with one of our staff members

Sincerely,
Grand Valley Rehabilitation Services Staff

Scheduling Communication Preference

Please Print

Patient Name: _____ **Date of Birth:** _____

In an effort to protect your privacy while allowing for efficient scheduling, please answer the following questions on how to contact you regarding scheduling issues:

□ No, it is NOT ok to leave messages or voicemails.
□ Yes, it is ok to leave messages or voicemails.

Preferred contact numbers where we may leave a message if answered yes:

□ Home Phone: (____) _____

□ Work Phone: (____) _____

□ Cell Phone: (____) _____

Persons authorized to receive messages/information at the above numbers for scheduling

_____ _____
Name Relationship Name Relationship

Only the people listed above will be able to confirm or change your appointment.

Please note: Above authorized persons requesting information, including appointment confirmations and changes, **must** provide us with information about you including name, date of birth and zip code.

Thank you for assisting us.

If the above was answered yes, it is ok to leave messages or voicemails, I authorize Community Hospital's Grand Valley Rehabilitation Services to leave protected health information inquiries that may include the following: name of patient, name and phone number of the clinic; name of treating therapist(s), appointment times and dates and scheduling information/requests.

_____ _____
Signature Date

Relationship, if not patient: _____

Cancellation/No Show/Co-Pay Policies

Thank you for choosing Community Hospital's Grand Valley Rehabilitation Services for your therapy needs. Due to the volume of new patients and limited appointments, we require that you notify our office 24 hours in advance if you are unable to keep your appointment. We understand that emergencies arise. In such cases, please contact us as soon as possible to cancel or reschedule your appointment.

Failure to call and cancel an appointment is considered a "No Show." After two such occurrences, any additional scheduled appointments will automatically be cancelled. Your therapist will consider you a discharged patient, and will send a note to your physician indicating non-attendance. You will have to contact your therapist to discuss continuation of therapy.

Along with quality treatment, it is the goal of this clinic to treat patients at their scheduled time. If you are more than 15 minutes late for your appointment, your appointment may need to be rescheduled.

Co-pays are collected prior to each treatment. Failure to pay may result in a bill from the health system's billing department.

We want to meet the goals of all of our patients, and we appreciate your assistance. Please let us know if there is something more we can do for you.

To cancel or reschedule appointment, please call (970) 644-3720.

Kyle Gardner
Director, Grand Valley Rehabilitation Services

I acknowledge that I have read and understand these policies.

_____ _____

Patient Signature Date

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Community HOSPITAL

Health Assessment Form

Personal Information

Name: _____ **Date of Evaluation:** _____

Occupation: _____ **Leisure Activities:** _____

Why have you been referred to therapy? _____

How and when did your condition occur? _____

What can you no longer do because of this condition? _____

Pain Information

Please indicate your current pain level by circling a number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Pain*

Please indicate your worst pain level by circling a number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

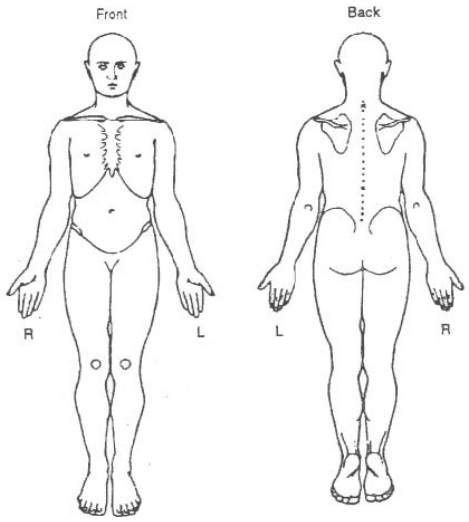
No Pain *Worst Pain*

Please indicate your best pain level by circling a number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Pain*

Please indicate on the body diagrams where your symptoms are located:



Please describes your pain (check all that apply)**:**

- □ Throbbing
- □ Sharp/Shooting
- □ Stabbing
- □ Burning
- □ Dull/Aching
- □ Numbness/Tingling
- □ Other _____

I currently have difficulty (check all that apply):

- □ Driving
- □ Walking
- □ Standing
- □ Bending at the waist
- □ Lifting
- □ Getting up from a chair
- □ Other _____

What makes your pain better? _____

What makes your pain worse? _____

Is your pain: □ constant OR □ fluctuating

Grand Valley
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Community HOSPITAL

Health Assessment Form

Have you had any of the following diagnostic tests done for your current condition?
If yes, please indicate approximate dates.

X-ray _____ MRI _____ CT Scan _____ Ultrasound _____ Other _____

Other Information

Have you experienced changes in how you feel in the past month?

In the past month, I have noticed a general change in my medical status. □ Yes □ No

In the past month, I have been feeling down, depressed or hopeless. □ Yes □ No

In the past month, I have been bothered by having little interest or pleasure in doing things. □ Yes □ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? □ Yes □ No

Condition Information

Please check the following symptoms you have experience in the past three months:

- □ Weight Loss / Gain
- □ Heartburn/Indigestion
- □ Fatigue - Unusual
- □ Swelling
- □ Problems Sleeping
- □ Constipation/Diarrhea
- □ Dizziness/Light-headedness
- □ Urinary Problems
- □ Heart Racing in your Chest
- □ Weakness
- □ Difficulty Swallowing
- □ Hearing Problems
- □ Regular Cough
- □ Tremor or Seizures
- □ Paleness
- □ Night Sweats
- □ Post-Menopause
- □ Excessive Bleeding
- □ Fainting
- □ Pregnant (or think you might be)
- □ Nausea / Vomiting
- □ Difficulty Breathing
- □ Numbness or Tingling
- □ Skin Rash
- □ Sexual Difficulties
- □ Blood in Stool
- □ Easy Bruising
- □ Stress at Home or Work
- □ Vision Changes/Eye Redness

Your input regarding the decisions of your therapy treatment and health care are important.

What would you like to accomplish through therapy? Please list your goals below:

1.
2.
3.

As part of your evaluation and treatment, our therapists strive to educate you on your current condition, as well as provide recommendations for treating your condition. Please help us to understand how we can provide a positive learning experience for you regarding your current condition and our treatment recommendations.

How do you learn (check all that apply):

- □ Seeing
- □ Hearing
- □ Doing

Do you need a translator to assist you during future visits? □ Yes □ No

If Yes, please indicate language: _____

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Health Assessment Form

Allergies

Please list any medication(s) you are allergic to: _____

_____

Are you latex sensitive? □ Yes □ No

Please list other allergies we should know about: _____

Have you declared the advanced Clinical Directive of "**Do Not Resuscitate**"? □ Yes □ No

Have you ever been diagnosed with any of the following conditions (check all the apply)**:**

		Date of Onset	**Therapist Use** Comments
□ Cancer	Type of Cancer _____		
□ Heart Problems	Type of Heart Issue _____		
□ High Blood Pressure			
□ Circulation Problems			
□ Asthma			
□ Stomach Ulcers			
□ Chemical Dependency			
□ Thyroid Problems			
□ Diabetes			
□ Multiple Sclerosis			
□ Rheumatoid Arthritis			
□ Other Arthritic Conditions			
□ Depression			
□ Hepatitis	Type: A B C		
□ Tuberculosis			
□ Stroke			
□ Kidney Disease	Type of Kidney Disease _____		
□ Blood Clots			
□ Osteoporosis			
□ Other			
□ Other			
□ Other			

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Health Assessment Form

Medical History Profile

Please describe any significant injuries for which you have been treated (including fracture, dislocation, sprains) and the approximate date of injury.

Date	Injury

Date	Injury

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Surgery/Hospitalization & Reason

Date	Surgery/Hospitalization & Reason

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Community HOSPITAL

Health Assessment Form

Medical History Profile

Please list all prescription medications, over-the-counter medications and herbal supplements that you are currently taking.

□ Copy attached with date of initial evaluation

Name	Medical Condition Prescribed For	Dosage/Frequency