HARBOUR REHABILITATION
(a Division of Wardell Orthopaedics, P.C.)

Name: _____

Physician: _____Patient ID: _____Other ID:_____

Prescription Date: _____

PATIENT ACKNOWLEDGEMENT

I acknowledge that Wardell Orthopaedics, P.C. has referred me to Harbour Rehabilitation for physical therapy services. It has been disclosed to me that Wardell Orthopaedics, P.C. has ownership in this facility and I have the freedom to select any other health care facility to provide the services prescribed for me.

PHYSICAL THERAPY POLICIES

1. Harbour Rehabilitation is open Monday thru Thursday from 8:00 a.m. to 5:00 p.m. and open Friday from 7:00 a.m. to 4:00 p.m.

2. **The patient's appointment may be cancelled if the patient arrives more than 15 minutes late for his/her appointment**. This will be determined on a case by case basis by the physical therapist.

3. Two unexcused absences or repeated cancellations may result in discontinuation of the remainder of treatments. **PLEASE CALL IF YOU CANNOT KEEP YOUR APPOINTMENT.**
   If you cancel, no show, or reschedule your physical therapy appointments excessively this may result in only being able to schedule 1-2 physical therapy appointments at a time.

4. Dress is casual. Please wear loose fitting clothing (sweat suit or athletic shorts/shirt and well-supported footwear, preferably sneakers).

5. **UNATTENDED CHILDREN UNDER THE AGE OF 12 YEARS OLD WILL NOT BE PERMITTED IN THE LOBBY OR IN THE TREATMENT AREA.** Only patients and personnel are allowed in the treatment area. Please make arrangements for someone to care for any child during the time of your treatment.

6. **Cellular phones are not allowed to be used in the treatment area, this includes texting**. All calls must be made outside of the building, secondary to interference with medical equipment and treatment.

7. If you have a prescription for physical therapy that is older than 30 days, conditions may have changed. Therefore, we may require you to be reevaluated by your physician before scheduling any physical therapy.

Your therapy program is designed to meet your needs and goals on an individual basis. We encourage you to offer comments at any time so that the staff can best address specific needs and goals. Our goal is to give you a good understanding of body mechanics and exercise techniques to enable you to continue to exercise and improve. This will help prevent re-injury after your discharge.

_____ _____

Patient Signature **Date**

HARBOUR REHABILITATION
(a Division of Wardell Orthopaedics, P.C.)
Patient Information

Name: _____Patient ID: _____Other ID:_____

TO BE COMPLETED BY PATIENT:
We ask you to complete this form before being seen by a physical therapist to help us assess the cause of your problem and to determine appropriate goals. Please answer as completely as possible.

MEDICAL HISTORY

Have you ever had? (check yes or no)	**YES**	**NO**	**Have you ever had? (check yes or no)**	**YES**	**NO**
Lung Disease			Dialysis		
Asthma - Inhaler?			Joint Replacements		
Diabetes			Hepatitis		
Epilepsy / Seizure Disorder			HIV (positive)		
Stroke			Metal Implants		
Heart Conditions			Muscle Disorder		
High Blood Pressure			Arthritis		
Pacemaker			Cancer		
Angina – Nitro?			MS / Lupus / Parkinson's / Fibromyalgia		
Osteoporosis			History of Falls-most recent_____		
Bowel/ Bladder Changes			WOMEN ONLY – Are you pregnant?		

PERSONAL DATA

1. Date of Birth: _____
2. Occupation: _____

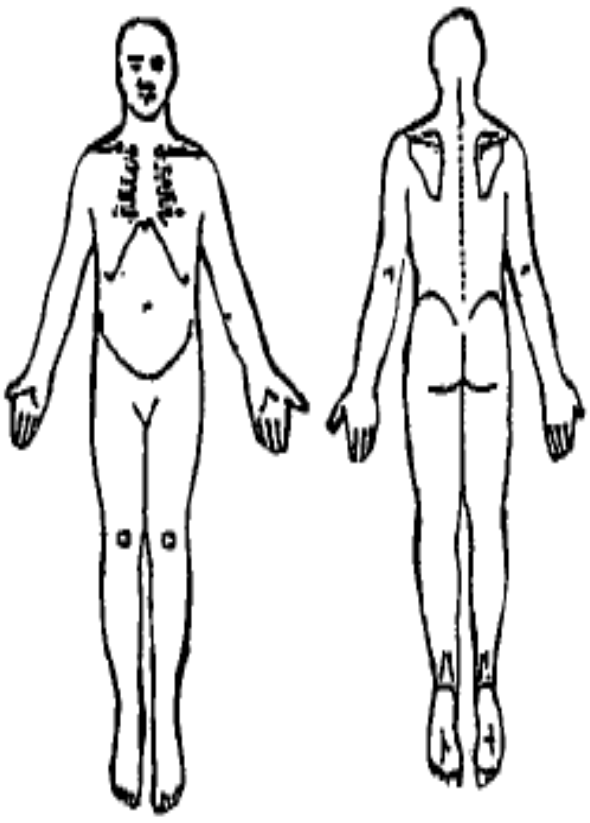
HISTORY:

1. How did your problem start? _____
   _____
2. What is your main complaint/ problem area?
   _____
   _____
3. It is important that we have a measure of your pain.
   Please circle the level of your pain on a scale of 1 to 10:

Mild Discomfort **Moderate Pain** **Extreme Agony**

0 1 2 3 4 5 6 7 8 9 10

4. Please indicate painful areas by shading the models to the right →



5. Any previous problems or surgeries related to injured areas?
   ____ Y ____ N If yes, please describe.
   _____
6. Have you fallen in the past 12 months?
   ____ Y ____ N If yes, how many and when?
   _____

_____ _____

Patient Signature **Date**