

Grand Traverse Pavilions
The Wellness Center

MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Date of Birth: _____

How did you hear about us?

- Family/Friend Advertisement Physician Prior GTP Participant/Patient
 Other: _____

About your current complaint...

1. What is the complaint that brought you here? _____

2. When did this complaint begin, or recently become worse?
Approximate date: _____

3. What caused this complaint? _____

4. Does this complaint affect your activities? Yes No
If "yes", what activities? _____

5. What makes this complaint better? _____ Worse? _____

6. Does this complaint affect your comfort, mood or ability to sleep? Yes No
Which ones? _____

7. What symptoms are you experiencing with this complaint?
 Swelling Loss of balance or coordination
 Loss of motion Numbness Pain: Draw pain areas below
 Weakness Tingling
 Other (specify) _____

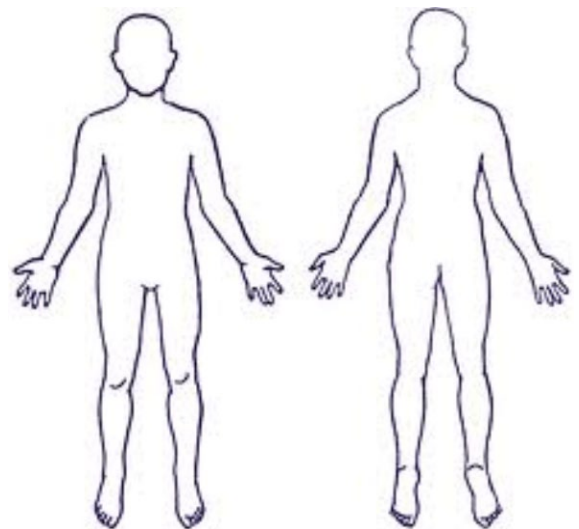
8. How frequent are the symptoms experienced?
 Constant Intermittent

9. How much pain are you experiencing?
 None Very Mild Mild Moderate
 Severe Very Severe

Pain Scale: (least) 1 2 3 4 5 6 7 8 9 10 (worst)

10. What tests have you had for this complaint?
 Xray CAT scan MRI Myelogram
 Bone Scan

Results: _____ Date of test: _____



11. What treatment have you had for this complaint? When? _____
 None Physical Therapy Occupational Therapy Athletic Training
 Chiropractic Alternative Medicine, please specify: _____

12. Are you currently being seen by any other therapist (PT/OT/ST)? Yes No

13. Is this complaint work related? Yes No

Your occupation: _____ Last date worked: _____

Work Status: Full-time Part-time Working Medical Restrictions
 Medical Leave

14. Is this complaint auto related? Yes No

General Health:

15. Please check all that apply:

- | | | |
|------------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Bowel or bladder control |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Smoke | <input type="checkbox"/> Other: |

16. Have you fallen recently? No 1-2 times/3 months 3+ times/3 months

17. Please list relevant surgeries: _____

18. Please list allergies: _____

19. Please list medications you are currently taking: See Attached

20. Do you use any assistive devices or adaptive equipment on a daily basis?
 Yes No

21. Do you have any problems with your vision not corrected by eyewear?
 Yes No Please list: _____

22. What goals do you want to achieve through treatment? _____

Signature

Date

Evaluating Therapist

Date

Welcome to The Wellness Center at the Grand Traverse Pavilions

We are pleased to be able to provide you with the services that you deserve as you work toward your personal physical goals. Be it on land or in water, your success and satisfaction are important to us.

Working as a collaborative team, both patient and therapist need to communicate with one another to succeed. We promise to act in only the highest professional manner and provide you with the knowledge and treatment strategies that will enhance your function.

In order to lay the foundation for a successful experience, we ask that you read the following to assist us in your treatment:

Weather: The pool will be closed during severe weather. You will be asked to exit the pool for a minimum of 30 minutes after thunder and lightning have been sighted/heard. The Wellness Center is open regardless of school closures. If there is severe weather and you are uncomfortable driving please call to cancel your appointment as soon as possible.

Cancellations: If you need to cancel an appointment, you must give 24 hour notice so that we may service another client. In the case of two cancellations with less than 24 hour notice, we reserve the right to charge a \$25 fee per visit cancelled. You will not be charged if you have an acute illness or there is severe weather preventing safe driving conditions to therapy. A third cancellation with or without proper notice for any reason (including medical conditions or illness) may result in a \$25 cancellation fee or discharge at the discretion of the organization.

No Show: You will be charged \$25 for a no call, no show. After two no call, no shows you will be removed from the schedule.

Tardiness: If you are going to be more than 10 minutes late, you must call the Wellness Center to determine if, in fact, your appointment is still available. We may be able to accommodate you but sometimes there will be a conflict with the next patient. If you do not call and are more than 10 minutes late, we will reschedule you as soon as possible and you will be charged \$25.

Home Programs: Improvement of many conditions occurs with consistent, regular performance of established exercises at home. It is your responsibility to understand the program your therapist has recommended, follow through at home, and be prepared to discuss the program with your therapist. She/He will need to modify it continuously to maximize therapeutic benefits.

Discharge: Discharge from therapy occurs for several different reasons including but not limited to insurance non coverage, client not meeting established insurance guidelines for continued therapy, plateau in progress, ability to complete program independently or with caregiver assist at home, non-compliance with home program, or lack of expectation of progress due to inconsistent attendance. Failure to attend scheduled appointments will result in discharge as outline above. The facility has the right to recommend care at another facility for future episodes of care if you have been discharged in the past due to any of the above issues.

Insurance: It is your responsibility to know your insurance coverage. Copayment is due at time of service and deductibles will be billed. **Medicare Part B as a secondary insurance** does not cover copayments or deductibles.

I have read and understand the above guidelines.

Signature: _____

Date: _____

Grand Traverse Pavilions
The Wellness Center

CONSENT TO TREAT RELEASE OF LIABILITY

I, _____, fully understand that the therapy programs and water exercise programs offered by Grand Traverse Pavilions require physical activity, and I hereby represent and acknowledge that my physical condition permits me to participate. I acknowledge that I have not been restricted from the physical activity I will embark on by any medical professional. I further acknowledge that I have been advised that at any time I am having physical difficulty of any kind to notify the Wellness Center personnel and carefully stop all activity. I have volunteered to participate in this program and accept the responsibility. I acknowledge and accept all of the risks.

I consent to the treatment plan developed by the professional therapy staff following a thorough evaluation. This plan was reviewed and agreed upon by my referring physician.

I realize that Grand Traverse Pavilions is not responsible for loss of or damage to any personal effects (money, jewelry, etc.) which I bring into the Wellness Center, and I agree to either, not bring such items into the Wellness Center; or, if I do, I will be responsible for such items.

I agree to abide by the Wellness Center rules and guidelines as stated by Grand Traverse Pavilions management whether written or stated verbally. I will conduct myself in a safe and acceptable manner at all times while at the Grand Traverse Pavilions Aquatic/Wellness Center.

I also agree to the release and discharge on behalf of myself, my heirs, assigns and successors in interest, all officers, directors, owners, agents and employees, and other representatives of Grand Traverse Pavilions and its insurers, from any and all claims, damages, demands, losses, and liabilities arising out of or in any way related to participation in any Grand Traverse Pavilions therapy programs, exercise programs, class activities, therapeutic procedures, aquatic therapy/swimming or any other activities or results attained therefrom.

I understand that the Grand Traverse Pavilions will make every effort to bill my insurance provider, but I am ultimately responsible for all charges incurred for services rendered at the Grand Traverse Pavilions. As a Grand Traverse Pavilions employee, all co-payments and any unpaid debts will be deducted from paychecks.

I also authorize the release of information necessary for communication among the health professionals who contribute to and assist with my care, as a means by which a third-party payor can verify that services billed were actually provided and assist Grand Traverse Pavilions in receiving payment for services and care provided to me and as a tool for routine healthcare operations and quality assurance studies.

The Grand Traverse Pavilions does not discriminate in providing care on the basis of race, color, religion, gender, national origin or disability.

Signed _____ Date _____

Printed Name _____