West Texas Rehabilitation Center **MEDICAL/SOCIAL HISTORY** **MRN #**

Name	DOB	Today's Date

What is the reason your doctor sent you for treatment and what do you want us to help you be able to do?

How long have you had this problem? *(please give a date or length of time)*

Medical History

***Are you receiving any home nursing or home therapy?** O Yes O No

(Is any healthcare provider coming to your home to check your blood pressure or give you medications?)

***If Yes, who is the home health agency?** ______________________________

Past Hospitalizations/Surgeries:

Please list medications that you are currently taking.

Medication	Prescribing Physician	Phone # of Prescribing Physician

Do you have any known medication allergies? O Yes O No **If Yes, please list**

Please place an "X" in front of all the answers that apply to you.

Which of the following medical conditions do you *currently* have and give dates to when this/these occurred?

O Asthma	O Paralysis	O Congestive Heart Failure	O Degenerative Joint Disease
O Emphysema	O Parkinson's	O Stroke	O Carpal Tunnel Syndrome
O Lupus	O Arthritis	O Traumatic Brain Injury	O Chronic Pain
O Diabetes	O Back Injury	O Chronic Bronchitis	O Depression, Anxiety and/or any other mental illness
O Heart Disease	O Vision Problems	O Hearing Problems	
O Cataracts	O Bone Fracture	O High Blood Pressure	O Cancer
O Alzheimer's	O Fibromyalgia	O Multiple Sclerosis	O Tuberculosis
O COPD	O AIDS/HIV	O Seizure Disorder	O Hepatitis O Other:
O Incontinence - Bladder		O Incontinence - Bowel	

Please indicate with an "X" whether you do them alone or with help.

Alone	With Help		Alone	With Help	
O	O	Walking	O	O	Getting in and out of bed
O	O	Eating/Swallowing	O	O	Getting in and out of chairs
O	O	Household activities	O	O	Getting in and out of the bath
O	O	Grooming/Bathing/Toileting	O	O	Speaking
O	O	Meal preparation	O	O	Hearing
O	O	Dressing	O	O	Remembering
O	O	Personal Finances	O	O	Problem Solving
O	O	Transportation			

Has your current illness or injury caused any of the following?

Yes	No		Yes	No	
O	O	Financial Stress	O	O	Sleep Disturbances
O	O	Family Problems	O	O	Irritability
O	O	Anger	O	O	Fear
O	O	Anxiety	O	O	Loss of Appetite
O	O	Sadness	O	O	Frustration
O	O	Depression	O	O	Suicidal Thoughts

Do you smoke? O Yes O No If yes, packs/day: ________

Do you currently have a **Universal DO NOT RESUSCITATE (DNR) Order?** If yes, please provide a copy. O Yes O No

Do you currently have a **Hospital Procedure-Specific DO NOT RESUSCITATE (DNR) Order?** O Yes O No

Are you seeing a Social Worker, Counselor, Psychologist, and/or Psychiatrist for your current troubles? O Yes O No

Would like to meet about a referral to a Counselor, Neuropsychologist , Social Worker or dietitian? O Yes O No

Printed name of person that completed this form, if not the patient **Relationship to the patient:**

Signature of person that completed this form: **Date:**

WEST TEXAS REHABILITATION CENTER

Patient's Name: Master Chart #

CONSENT FOR TREATMENT

I, the undersigned, am the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and do hereby voluntarily consent to and authorize West Texas Rehabilitation Center, Inc., (WTRC), a Texas non-profit corporation, or other related entities to administer treatment as per the doctor's orders.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION OF RELEASE OF INFORMATION

I hereby assign to WTRC all benefits provided under any healthcare plan, medical policy, motor vehicle insurance and/or any other entities paying on my behalf, otherwise due or payable to me provided the amount of such benefits shall not exceed the amount of said professional service charges. I understand that I am personally responsible to WTRC for all charges not covered by this assignment and that a photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any records/information, including papers, forms, videos, photographs and other records pertinent to my case, to any insurance company, adjuster, medical case manager, employer, physician or other medical entity, or attorney involved in the case.

PAYMENT POLICIES

1. Although you may be assisted by private insurance, Worker's Compensation, Medicare, Medicaid or even WTRC's Donor Sponsorship Program, payment for services received by you or your family is ultimately your responsibility. Cash, personal checks and major credit cards or debit cards are accepted.
2. Payment is required at the time of service if you have an insurance plan that dictates a per visit co-payment. Patients who do not have such a feature in their insurance coverage will be mailed a statement indicating their financial responsibility for the services provided.
3. WTRC is committed to assisting families with their financial responsibilities. The Donor Sponsorship Program is designed to identify families with various levels of need and provide them with corresponding assistance. Our staff will be glad to assist you in determining your eligibility for assistance. Before that process can begin, however, we need to know that you would like to seek assistance and are willing to provide the needed information.

WTRC hopes that this information helps to clarify our policy. If at any time you have a question or you would like to be reconsidered for sponsorship based on new information, do not hesitate to ask the Admissions staff.

THIRD PARTY DISCLOSURES I, ______________________________, am the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and give the following person(s) or representative(s) permission to discuss appointments, medical treatments and/or any financial matters on my behalf.

______________________ (______________) ______________________ (______________)

Printed Name Relation (Phone) Printed Name Relation (Phone)

Please circle "yes" or "no":

Y N I grant permission for WTRC personnel to leave messages on my home voice mail and/or cell phone.

Y N I grant permission for WTRC personnel to leave messages on my work voice mail, if applicable.

Y N I wish to receive emails from West Texas Rehabilitation Center. If Yes, Email: ______________________

I have been offered a copy of the appropriate orientation to West Texas Rehabilitation Center. I have been offered a copy of the Notice of Information Practices in the WTRC Patient Handbook, which describes how medical information about you may be used and disclosed and how you can get access to this information. If after reviewing the Notice, you should have any questions, our Admissions staff would be glad to answer them.

______________________________ ______________________________

Signature of Patient or Guardian Date WTRC Witness Date