HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

HRRMC Rehabilitation Services—Buena Vista

28374 CR 317, Buena Vista, CO 81211 • 719-395-9048

Welcome to the HRRMC Rehabilitation Department in Buena Vista!

We look forward to getting you on a path of healing to optimize your lifestyle and your function!

In order to expedite your initial treatment session, we would like you to fill out a few items **PRIOR** to your appointment. Please fill out the attached documentation and **bring all completed forms with you to your first appointment.**

In addition, please **call the preregistration number 719-530-2360 at least 48 hours PRIOR to your appointment.** This will decrease the amount of time required to register you on the day of your appointment.

As you know, we are very busy. Should you need to cancel or reschedule your appointment, please be respectful of our therapists' time as well as other patients, and give us the courtesy of 24-hour notice.

Call 719-395-9048 at least 24 hours before your scheduled appointment should you need to cancel or reschedule.

Reminder: On the day of your evaluation, please arrive 15 minutes prior to your scheduled appointment time!!

We look forward to meeting and caring for you!

Sincerely,
The HRRMC Rehabilitation Department

HEART OF THE ROCKIES REGIONAL MEDICAL CENTER

Outpatient Rehabilitation Intake

Patient Name:
Patient DOB:
Patient Number:
Admit/Visit Date:

Or Patient Label

Therapist Name:_____ Date of Eval:_____

Please complete the following. Feel free to ask your therapist for assistance with any items.

Last Name_____ First Name_____

Date of Birth_____ ☐ MALE ☐ FEMALE Height_____ Weight_____ ☐ RIGHT Handed ☐ LEFT Handed

Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Where may we phone you and leave a message regarding your current treatment? ☐ Home ☐ Work ☐ Mobile

Reason for this visit? _____

Approximate Date of Onset: _____

What makes your symptoms better? _____

What makes your symptoms worse?_____

Occupation: _____ ☐ Full time ☐ Part time ☐ Not employed ☐ Retired

Describe your regular physical activities:

_____

Type of imaging study done for this condition? ☐ None ☐ MRI ☐ X-RAY

OTHER: _____

Y	N	
☐	☐	Are you pregnant? If so, how many weeks? _____
☐	☐	Do you have a pacemaker/defibrillator?
☐	☐	Have you had a joint replacement? If so, which joints? _____
☐	☐	Are you allergic to lotions/latex /tape/ menthol/medications? If so, please list: _____
		_____
☐	☐	Do you have adequate physical support at home to meet the challenges of your condition?
☐	☐	Do you feel safe at home?

Please list major injuries, surgeries or hospital stays (with reason for stay) and approximate dates:

In the past 6 months, have you had:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Difficulty with bowel/bladder control	☐	☐	Fever/Chills	☐	☐	Headache	☐	☐	Leg Swelling
☐	☐	Numbness in the genital or anal area	☐	☐	Numbness	☐	☐	Weakness	☐	☐	Nausea
☐	☐	Pain that wakes you at night	☐	☐	Dizziness	☐	☐	Shortness of breath	☐	☐	Chest pain
☐	☐	Unexplained weight change	☐	☐	Numbness	☐	☐				

Other: _____

Have you fallen in the last 6 months? ☐ Yes ☐ No If yes, how many times? _____

Have you ever been diagnosed as having any of the following:

Y	N		Y	N		Y	N	
☐	☐	Cancer	☐	☐	Emphysema/Bronchitis	☐	☐	Rheumatologic Conditions
		If yes, what kind?_____	☐	☐	High Blood Pressure	☐	☐	Neuropathy
☐	☐	Stroke	☐	☐	Anemia	☐	☐	Epilepsy/Seizures
☐	☐	Heart Problems	☐	☐	Thyroid Problems	☐	☐	Multiple Sclerosis
☐	☐	Kidney Disease	☐	☐	Osteoporosis/Osteopenia	☐	☐	Parkinson's
☐	☐	Diabetes	☐	☐	Smoking	☐	☐	Other Neurologic Diagnoses
☐	☐	HIV/AIDS	☐	☐	Arthritis			If yes, what kind?
☐	☐	Hepatitis	☐	☐	High Cholesterol			
☐	☐	Tuberculosis	☐	☐	Chemical Dependency/Alcoholism			
☐	☐	Asthma	☐	☐	Depression			

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Outpatient Rehabilitation Intake

Patient Name:
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Patient Number:
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Other Conditions:

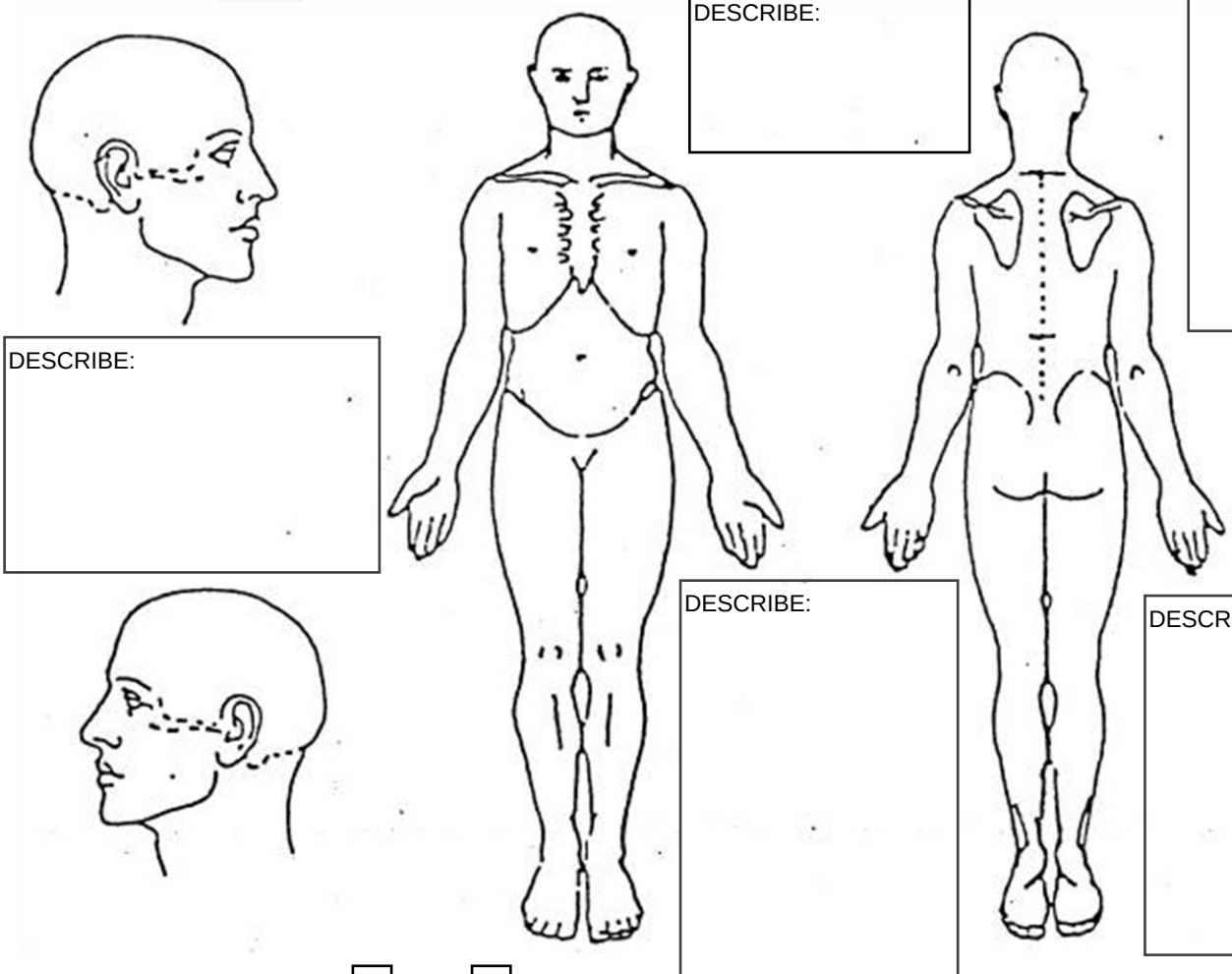
What prescription medications are you currently taking and what quantity? (include pills, injections, and skin patches)

Please check the number that best describes how your symptoms feel at your WORST:

No Discomfort **Worst Possible Discomfort**

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Hurt	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts

Please mark and describe the areas where you feel symptoms (label pain, tingling, numbness, etc.) You should be able to mark with the Adobe tool



DESCRIBE:

DESCRIBE:

DESCRIBE:

DESCRIBE:

DESCRIBE:

Form reviewed with patient? ☐ **YES** ☐ **NO**

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Office Use Only

Patient: Last Name _____ First _____

DOB: _____ Provider Name: _____

REHABILITATION SERVICES | Cancellation Policy—Buena Vista Location

HRRMC Rehabilitation Services strives to provide exceptional care to our clients and their families. We aim to provide care in ways that best meet your needs and your schedule. However, missed appointments and frequent cancellations do impact our ability to provide quality services. Please take a moment to review our policies. These policies have been created to ensure that you receive the care and information you need.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

A notification of cancellation is required at least 24 hours prior to the appointment or earlier if possible. If you are unable to attend an appointment, please let us know by calling **719-395-6641**. The answering machine will take a message for you if it is after business hours. Please be sure to include your name, date and time of appointment.

NO-SHOW AND CANCELLATION POLICY: If you have 3 no-shows or cancellations less than 24 hours prior to your appointment, your therapist may decide the following:

1. **Discharge you from therapy:**
   a. All future appointments will be cancelled.
   b. You may need to return to your doctor for a new prescription to resume therapy.
2. **You may be placed on a "call-in only" status:**
   a. All future appointments will be cancelled. You'll be responsible for contacting us at **719-395-6641** on a day that you are available for therapy.
   b. The front office staff will look at your therapist(s) schedule to see if there is an opening for you on that day. If there is an opening, you will be offered an appointment at that time.
   c. If there is not an appointment opening that day, you will need to call back the next day that works for you to check the schedule again.
   d. Your therapist may change your status after proof of consistent attendance.
   e. Failure to show or if you cancel a call-in appointment will result in you being discharged from therapy.

LATE ARRIVAL: We understand that delays can happen however we must try to keep the other patients and therapists on time. Because of the individualized care required for each patient, it may be necessary to reschedule your appointment if you arrive more than **15 minutes later than your scheduled appointment time.**

ILLNESS: If you are experiencing a fever or contagious illness, please reschedule your appointment out of respect for patients with compromised immune systems that receive therapy. This will ensure that HRRMC Rehab remains a healthy clinic in which to receive excellent care.

Thank you for your understanding and cooperation.

_____ _____

Patient or Authorized Representative Signature | Date Signed

_____ _____ _____

Witness Printed Name | Signature | Date Signed