NOCONA GENERAL HOSPITAL REHABILITATION

The Rehabilitation Services department at Nocona General Hospital is dedicated to improving the health, well-being and overall function of the people in and around our surrounding community. We strive to assist in attaining maximum function, a sense of well-being, and a satisfying and realistic level of independence. Nocona General offers physical therapy (PT) and speech therapy (ST) services to individuals in home health, hospital and outpatient settings.

Adults and children who qualify for PT services will receive a comprehensive evaluation and individualized plan of care to address functional limitations, muscle weakness, pain, range of motion limitations, balance deficits, and endurance issues. Patients with cognitive, memory, speech and/or communication impairments are evaluated and treated by a speech/language pathologist. A physician prescription is required to receive rehabilitation services. Outpatient services are provided Monday through Friday from 8 a.m. to 4:30 p.m

Types of patients likely to receive services include, but are not limited to:

- Orthopedic - Total joint replacement, fractures, sprains/strains
- Neurological - Stroke, balance disorders
- Work Related - Back/neck injury, hand trauma, carpal tunnel syndrome
- General Illness - COPD, CHF, arthritis, general surgery
- Wounds – Diabetic, pressure, vascular, burns
- Speech/Language – Stroke, traumatic brain injury, speech/swallowing/cognitive difficulties

Wellness Center

Our 10,000 square foot Wellness/Rehab Center is open to the community Monday through Friday from 5:30 a.m. to 9 p.m., Saturday 7a.m to 3 p.m., and Sunday from 1 p.m. to 6 p.m.

Individuals pay a monthly fee for use of the facility, which includes treadmills, elliptical machines, stair steppers, stationary bicycles, a multi-station weight machine, and free weights.

Have questions? Contact us!

Nocona General Hospital
100 Park Rd
Nocona, TX. 76255
PT phone: 940-825-7246 (PAIN)
PT fax: 940-825-3323

PHYSICAL THERAPY
CONFIDENTAL HEALTH HISTORY

Name:_____ **Date:**_____ **Gender: Female Male**
Age: _____ **Weight:** _____ **Occupation:**_____ **Last day worked (if applicable):** _____

Is anyone currently coming to your home to give you health care? ☐ Yes ☐ No

Current Symptoms: Describe the problems you are experiencing currently.

_____

_____

How did your symptoms begin? Trauma, gradual, sudden? _____

_____

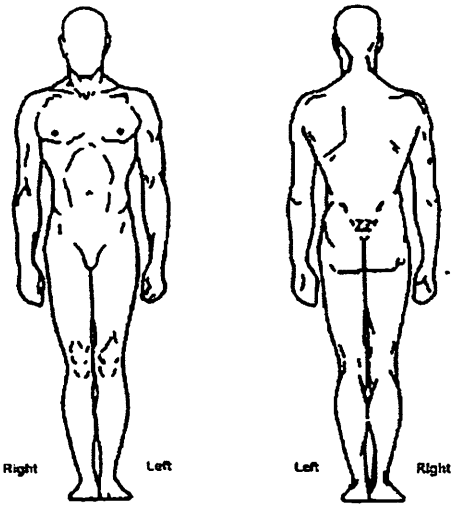
When did you first notice these symptoms? (Use specific day if trauma/accident) _____
Date of most recent flare up: _____
Describe your symptoms: _____

Using the diagram below, mark all area(s) where you are experiencing symptoms.
Use the symbols to describe symptoms:

	Aching	Numbness	Pins and needles	Burning	Stabbing
Are your symptoms?:					
☐ Getting better					
☐ Staying the same	****	====	OOOO	XXXX	////
☐ Getting worse					

What makes your symptoms WORSE?:
- ☐ Walking / Standing _____
- ☐ Sitting / Bending _____
- ☐ Lying Down (face up / face down / side)
- ☐ Movement _____
- ☐ Other _____

What makes your symptoms BETTER?:
- ☐ Walking / Standing _____
- ☐ Sitting / Bending _____
- ☐ Lying Down (face up / face down / side)
- ☐ Movement _____
- ☐ Other _____



Frequency of symptoms:
- ☐ Constant (76-100% of the day)
- ☐ Frequent (51-75% of the day)
- ☐ Occasional (26-50% of the day)
- ☐ Intermittent (0-25% of the day)
- ☐ Less than Daily _____

Please rate your pain:

0	1	2	3	4	5	6	7	8	9	10
None					Moderate					Need to go to ER/hospital

Have you had any injections or other treatment for these symptoms? No / Yes Dates_____

Which tests have you had for this condition? ☐ X-ray ☐ MRI ☐ EMG ☐ CT ☐ Bone scan ☐ Other
Describe the test results_____

When is your next appointment with the doctor who requested this therapy? _____

Are you CURRENTLY under the care of another health professional in addition to the one prescribing Physical Therapy? No / Yes For what condition(s):_____

Have you ever had physical/occupational therapy prior to this occasion? No / Yes

Prior Function and Environment

Please describe your living arrangements *prior* to the onset of this condition:

□ House □ Apartment □ With spouse/family member □ Alone □ Daytime caretaker □ Other _____

Who is responsible for household tasks such as cleaning and preparing meals?

□ Self □ Spouse/family member □ Daytime caretaker □ Other _____

How often did you drive yourself around the community?

□ Always □ Frequently □ Occasionally □ Rarely □ Never

When you are out in the community, do use an assistive device?

□ Wheelchair □ Walker □ Cane □ Crutch(es) □ Other _____

Medical History (Check all conditions you **HAVE** or **HAD** in the past) ☐ **Check box if NO to all below**

□ AIDS	□ Changes in vision/hearing	□ HIV positive	□ Pneumonia
□ Alcoholism	□ Depression	□ Joint pain	□ Pregnant NOW /RECENT
□ Anemia	□ Diabetes	□ Low blood sugar	□ Psychiatric care
□ Anorexia	□ Dizziness	□ Kidney disease	□ Shortness of breath
□ Appendicitis	□ Emphysema	□ Liver disease	□ Smoker ____# packs/week
□ Arthritis	□ Epilepsy	□ Migraine headaches	□ Weight gain / loss
□ Asthma	□ Fractures / dislocations	□ Multiple Sclerosis	□ Heart attack / disease
□ Bleeding disorders	□ Fibromyalgia	□ Myofascial pain syndrome	□ Heart surgery
□ Bronchitis	□ Hepatitis	□ Neurological disorders	□ Chest pain
□ Bowel or bladder difficulty	□ Hernia	□ Night sweats	□ High blood pressure
□ Bulimia	□ Hemorrhaging	□ Pacemaker	□ Stroke
□ Cancer	□ High cholesterol	□ Persistent night pain	□ Other

Medications (List all medicines you are currently taking) Allergies (Substances/medicines)

Surgeries (List ALL previous procedures. Eg heart, abdominal, bone, ligament, other)

Patient Goals: What do you hope to gain through therapy?

□ Decrease pain □ Increase motion □ Return to specific activity _____

□ Increase strength □ Improve function □ Other _____

Do you use the internet to learn about your health/ your current condition?: No / Yes

What would be your ideal physical therapy treatment:

□ Have regular assistance/guidance with exercises. □ Just show me how to do so I can do on my own

□ To learn about what the problem and the solution. □ I just want help to fix the problem

Please rank the following in regard to your health care needs: (1= most important, 4= least important)

_____Experience _____Outcomes _____Price _____Convenience

Please rank how you see yourself/ your personality: (1= most , 4= least)

_____Guardian _____Artisan _____Idealist _____Rationalist

Thank you for taking time to complete this evaluation. Our staff hopes to provide you with excellent care to reduce your symptoms and restore you to normal function.

Patient signature _____ **Date** _____

Therapist Signature _____ **Date** _____

Nocona General Physical Therapy

Patient Information Page 1 of 2

*We cannot process your insurance claim without the required fields filled out

Patient's name*: _____ Today's date:_____
Street address*: _____SSN*:_____
City and State*:_____ Male__ Female__
Zip Code*: _____Home phone:_____ Date of Birth*: _____/___/___
Work phone:_____ Cell: _____ Age: _____
Email:_____
Family Physician:_____ Phone:_____
Person to contact in case of emergency: _____
Phone: (_____)_____ Relationship: _____
Have you ever been seen a patient here before? Yes__ No__ Date seen? _____

PRIMARY INSURANCE COMPANY NAME:_____
Group number: _____ Policy number: _____
Insurance company billing address: _____
Policyholder's name*:_____ Relationship to patient:_____
Policyholder's date of birth*:_____ / ___ / ___ Male __ Female __
Policyholder's SSN*:_____
Place of employment:_____
Employer's street address:_____
SECONDARY INSURANCE COMPANY NAME:_____
Policy number: _____ Group number: _____
Insurance company billing address:_____
Policyholder's name*:_____ Relationship to patient:_____
Policyholder's date of birth*:_____ / ___ / ___ Male __ Female __
Policyholder's SSN*:_____
Place of employment:_____
Employer's street address:_____

IS THIS A WORKER'S COMPENSATION CLAIM? Yes __ No __
Date of Injury:_____
Company:_____ Address:_____
Phone Number:_____ Claim #:_____
Contact Person: _____

IS THIS AN ACCIDENT CASE? Yes __ No__ Vehicle __ Other: _____
Insurance Company to Bill: _____ Adjuster Name:_____
Address: _____
Street City State Zip
Phone #: _____ Claim#: _____

100 Park Rd Nocona, Texas 76255 (940)825-7246 Fax(940)825-3323 Email: noconapt@noconageneral.com

Nocona General Physical Therapy

Patient Information Page 2 of 2

How did you obtain our name?
Friend __ Physician __ Internet __ Web site __ Other _____

Referring Doctor: _____ Phone: _____ Last Appt. _____
Is there pending litigation concerning your injury? No __ Yes __
If yes, attorney name: _____ Phone: _____
Attorney address: _____

Result of Auto Accident Yes __ No __ Date_____
Result of Work Injury Yes __ No __ Date_____
Place of employment at time of injury: _____ Phone: _____
Current place of Employment: _____ Occupation: _____

I consent to NGH Physical Therapy for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Nocona General Hospital Physical Therapy to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:
Worker's Compensation __ Patient/Guardian __ Attorney __ Rehabilitation Intermediary __

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to NGH Physical Therapy. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from NGH Physical Therapy.
Print Name: _____
Client's Signature: _____ **Date:** _____

I have read and understand NGH Physical Therapy privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request.

Client's Signature: _____ **Date:** _____

I have read and understand Nocona General Hospital's billing and collection policies, initial disclosure, and cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.

Client's Signature: _____ **Date:** _____

Responsible Party's Signature (if patient is a minor)_____ Date: _____

Witness Print name _____ **Witness Signature**_____ **Date:** _____

100 Park Rd Nocona, Texas 76255 (940)825-7246 Fax(940)825-3323 Email: noconapt@noconageneral.com