The Wellness Center
GRAND TRAVERSE PAVILIONS

MEDICAL HISTORY QUESTIONNAIRE

Name: _____
Date of Birth: _____
Date of Evaluation: _____

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?_____

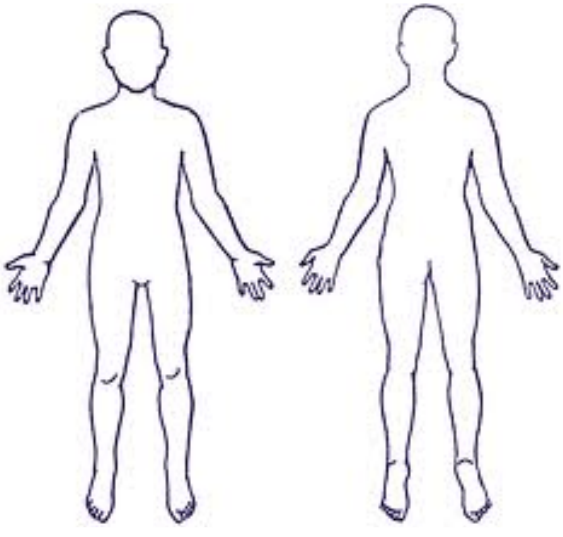
4. Does this complaint affect your activities? Yes No
   If "yes", what activities? _____

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?
    □ X-ray □ 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:

□ Arthritis	□ Lung Disease	□ Thyroid Problems
□ Cancer	□ High Blood Pressure	□ Anxiety
□ Diabetes	□ Stomach Disorder	□ Depression
□ Heart Disease	□ Pace Maker	□ Hearing Problems
□ Visual Problems	□ Learning Problems	□ Bowel or bladder control
□ Pregnant	□ Smoke	□ 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:

Attending your scheduled sessions is critical to the success of your therapy. We ask that you come to your appointments as scheduled. The success of your therapy requires commitment to your own health!

Cancellations: If you need to cancel an appointment, you must give 24 hour notice so that we may service another client. Any cancellation made with less than 24 hour notice will incur a $25 cancellation fee.

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.

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.

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:_____

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 it's 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 payer 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.

Printed Name: _____

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The Wellness Center at the Grand Traverse Pavilions

I acknowledge

I was able to review and receive a copy of the Grand Traverse Pavilions Notice of Privacy Practices on _____.
(Date)

The Notice of Privacy Practices was presented in a location where I was able to read the Notice of Privacy Practices.

I was offered a copy of the Notice of Privacy Practices to take with me. I was able to view the Notice of Privacy Practices on the first day I received health care services after April 14, 2003.

If I came in for health care services in an emergency treatment situation, I was Able to view the Notice as soon as reasonably practicable after the emergency Treatment situation.

_____
Print Constituent Name

_____
Constituent or Constituent Representative Signature Date

_____
Provider Representative Signature Date

If an acknowledgment is not obtained, document below provider's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained.

_____

_____

_____

_____