PATIENT REGISTRATION FORM
Wendell Foster's Outpatient Therapy Services

PATIENT NAME _____
(Last) (First) (MI) (SOC SEC #)
STREET OR BOX NO _____ **CITY** _____ **ST** _____ **ZIP** _____

COUNTY _____ ___ **FEMALE** ___**MALE** **RACE** _____ **BIRTH DATE** _____

DIAGNOSIS _____ **REFERRAL SOURCE** _____

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Responsible Party #1

NAME _____
ADDRESS _____
CITY _____ **ST**_____ **ZIP**_____
HM PH _____ **CELL** _____
SOC SEC # _____ **BIRTH DATE**_____
E-MAIL _____
EMPLOYER _____
EMPL ADD _____ **PH**_____

Responsible Party #2

***NAME** _____
***ADDRESS** _____
* **CITY** _____ **ST**_____ **ZIP**_____
* **HM PH** _____ **CELL** _____
* **SOC SEC #** _____ **BIRTH DATE**_____
* **E-MAIL** _____
* **EMPLOYER** _____
* **EMPL ADD** _____ **PH**_____

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PRIMARY INSURANCE

NAME OF INS_____
ADDRESS _____
CITY _____**ST** ____ **ZIP**_____
PHONE _____ **EFFECTIVE DATE** _____
POLICY HOLDER NAME _____
POLICY ID/GRP # _____

SECONDARY INSURANCE

NAME OF INS_____
ADDRESS _____
CITY _____**ST** ____ **ZIP**_____
PHONE _____ **EFFECTIVE DATE** _____
POLICY HOLDER NAME _____
POLICY ID/GRP # _____

PRIMARY CARE PHYSICIAN & ADD _____

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ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT: **I hereby authorize my signature on all insurance and Medicare claim forms at the office of Wendell Foster's Campus for payment directly to him/her for service rendered to me/patient. I authorize this office to make and send copies of medical records that may be needed to file my insurance claims. I understand that I/patient am responsible for charges incurred regardless of whether my insurance pays or not. I understand that if any unpaid balance is assigned to a third party collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33 1/3 % will be added to my account. I agree to pay that fee. I understand that if I have an outstanding collection balance it must be paid before starting or continuing treatment. I also agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.**

SIGNATURE _____ **DATE** _____

Wendell Foster
Empowering People With Disabilities

Comprehensive Outpatient Rehabilitation Facility
815 Triplett Street
Owensboro, KY 42303
(270) 689-1738

Thank you for scheduling an evaluation at Wendell Foster's Campus. Please complete the following information in order to ensure that the scheduled evaluation is completed as best as possible. Thank you for your time.

Name: _____ Date of Birth: _____
Emergency Contact Name: _____ Contact Phone Number: _____
Name of person completing form if not self: _____
What language do you speak? _____

What services are you seeking from Wendell Foster's Campus?
☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy

What would you like to achieve through Wendell Foster's Outpatient Services?
_____
_____
_____

Do you have specific concerns?
☐ History of falls
☐ Behavioral concerns/Sensitivity to environment
☐ Writing/Manipulating small objects
☐ Communication: ___Speech difficulty ___Use of devices ___Hearing difficulty
___ Trouble understanding commands/instructions
☐ Transfers (need assistance in/out of bed, chair, on/off toilet)
☐ Self Care Skills (need assistance with bathing, dressing, grooming, feeding)
☐ Memory
☐ Walking
☐ Other: Please describe _____

Have you received therapy services for this concern prior to now?
_____

Was this a result of an accident? _____

Are there specific things that you are unable to do? Are there specific tasks at home that are difficult for you? When did you first start having trouble?

_____

_____

_____

Medical History:

Diagnosis: _____ Date of Diagnosis: _____

Please list the date of the onset of any of the conditions below. When did you first experience symptoms?

- ☐ Diabetes:
- ☐ Dementia:
- ☐ ALS/Lou Gehrig's Disease:
- ☐ Heart Problems:
- ☐ Metal Implants/Hardware:
- ☐ Recent Surgeries:
- ☐ Ventilator Dependent:
- ☐ Seizures:
- ☐ Brain Injury:
- ☐ Cerebral Palsy:
- ☐ Allergies:
  - ☐ Food:
  - ☐ Seasonal/Environmental:
- ☐ Respiratory Problems (COPD, Shortness of Breath):
- ☐ Stroke:
- ☐ Parkinson's:
- ☐ Autism:
- ☐ Hypertension:
- ☐ Arthritis:
- ☐ Circulatory Problems:
- ☐ Hearing Loss/Difficulty:
- ☐ Recent Fractures:
- ☐ Multiple Sclerosis:
- ☐ Cancer:
- ☐ Vision Problems:
- ☐ Fainting/Dizzy Spells:
- ☐ Eating/Swallowing Problems:
  - ☐ Use of G-Tube:
  - ☐ Special Diet:

What medications, vitamins, or supplements are you currently taking?

Medication	Dose	How Often?	Who Prescribed?

Please list the Doctors involved in your care:

Type of Doctor	Name	Facility
☐ Physical Medicine/Rehab		
☐ Neurologist		
☐ Optometrist		
☐ Ophthalmologist		
☐ Orthopedist		
☐ Urologist		
☐ Pulmonologist		
☐ Genetics		
☐ Gastroenterologist		
☐ Psychologist		
☐ Psychiatrist		
☐ Other:		
☐ Other:		

Have you participated in Medical Rehabilitation in the last year?

Service	When?	Provider
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Other:		

Are you currently receiving any services such as home health care/hospice care from any other organization?

☐ Yes ☐ No Explain: _____

Do you have any doctor instructed restrictions or precautions?

☐ Yes ☐ No Explain: _____

Home Environment:

What type of home do you live in? ☐ SCL ☐ Assisted Living
☐ Apartment ☐ House ☐ Mobile Home ☐ Group Home ☐ Nursing Home

How long have you lived at this location? _____

Do you have anyone to help you at home? ☐ Yes ☐ No
If yes, who? _____ How often? _____

Is your home ☐ Single level ☐ Multi-level
Do you have stairs? ☐ Yes ☐ No
If yes, how many stairs to get into your home? _____
How many stairs to go to other levels? _____

Do you have any special equipment at home? ☐ Yes ☐ No
If yes, please list: _____

Have there been any special modifications/changes made to your home? ☐ Yes ☐ No
If yes, please list: _____

Please list all of the persons living with you:

Name	Age	Relationship

Communication:

How do you communicate with others? ☐ Gestures ☐ Pictures ☐ Single words
☐ Speak in sentences ☐ Sign language ☐ Other: Explain _____
☐ Device: What device do you have? _____
When did you get the device? _____
☐ Communication Board

Approximately how many single words do you use? _____
Do you have trouble speaking in complete sentences? _____
Are you able to spell out words on a keyboard? ☐ Yes ☐ No
Are you able to read? ☐ Yes ☐ No
If no, are you able to recognize: Letters ☐ Yes ☐ No Numbers ☐ Yes ☐ No
Pictures ☐ Yes ☐ No
How much of what you say to those who know you is understood?
☐ Almost all (100%) ☐ Most of it (75%) ☐ About half (50%) ☐ Just a little (25%) ☐ Almost none (0%)

How much of what you say to strangers is understood?
☐ Almost all (100%) ☐ Most of it (75%) ☐ About half (50%) ☐ Just a little (25%) ☐ Almost none (0%)

Are you able to follow single step directions?
☐ Yes ☐ No ☐ Sometimes

Are you able to follow multi-step directions?
☐ Yes ☐ No ☐ Sometimes

Do you have problems with your vision? ☐ Yes ☐ No
If yes, do you wear glasses? ☐ Yes ☐ No

Do you have problems with your hearing? ☐ Yes ☐ No
If yes, do you wear hearing aids? ☐ Yes ☐ No

Other Information:

Do you currently work? ☐ Yes ☐ No
If yes, where do you work? _____
Describe the type of work you perform:
_____

What are some of your favorite activities, games, hobbies?
_____
_____

Anything else the therapist should know before treating you?
_____
_____