# Central Vermont Medical Center

***Rehabilitation Services Department – Outpatient Intake Questionnaire***

**Name:**_______________________________________________________________________**Date:**_________

Home #: ___________________________Work #: _____________________Cell #:_______________________

May we leave a telephone message on your answering machine, at home and/or business and/or cell? Yes ☐ No ☐

What problem/condition brought you to rehabilitation services?_________________________________________

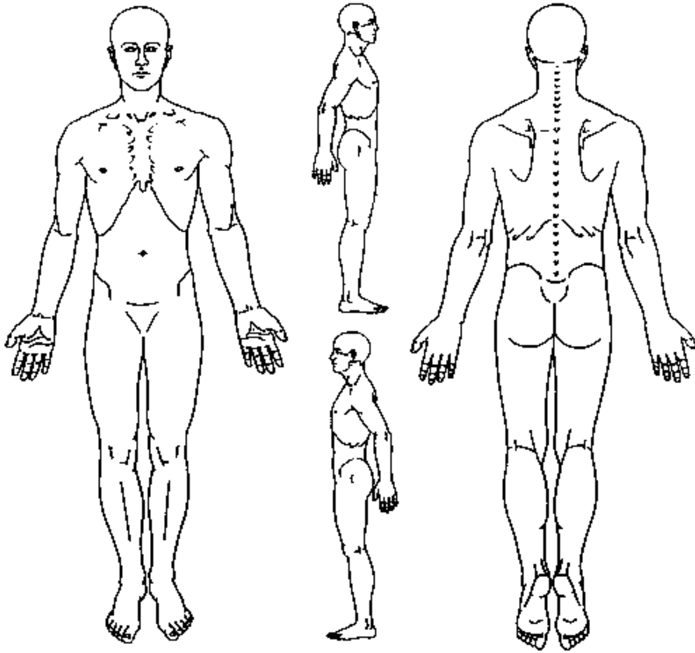
When did this problem begin? ___________________________________________________________________

Are you receiving home health services currently? ___________________________________________________

On a scale of zero to ten, circle your level of pain:
**0=NO PAIN, 10=WORST PAIN-POSSIBLE (would cause you to faint or go to the emergency room)**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **At rest** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **At worst** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

Please describe the pain that you are experiencing and mark the location on the drawings below:



Please list any medications that you are currently taking (or provide a list we can photocopy):.___________________

_____________________________________________________________________________________________

We occasionally have a therapy dog on premises. Are you allergic or aversive to dogs? Yes ☐ No ☐

What is your occupation?______________________________________________________________________

Is this injury work-related and filed with your employer? If so please provide Worker's Compensation information:

Company Name:________________________________Telephone:___________________________________

Check all conditions that apply to you:

- ☐ Respiratory Problems
- ☐ Asthma
- ☐ Pneumonia

- ☐ Cardiac Problems
- ☐ Circulation Problems
- ☐ Gastrointestinal Problems

- ☐ Neurological Problems
- ☐ Diabetes
- ☐ High/Low Blood Pressure
- ☐ Thyroid Problems
- ☐ Kidney/Bladder Problems
- ☐ Prostate Problems
- ☐ Cancer

- ☐ Arthritic Conditions

- ☐ Adenoidectomy
- ☐ Tonsillitis
- ☐ Tinnitus
- ☐ Laryngitis

- ☐ Obesity
- ☐ Tobacco Use
- ☐ Alcohol/Drug Abuse

- ☐ Head Injury
- ☐ Hearing Impaired
- ☐ Vision Problems
- ☐ Ear Infection
- ☐ Headaches
- ☐ Stroke/CVA
- ☐ Seizures
- ☐ Osteoporosis

- ☐ Polio

- ☐ Pregnancy

- ☐ Emotional/Mental/Depression

- ☐ Allergies__________
- ☐ Latex Allergy

- ☐ Infectious Diseases (mrsa,vre,Hep,HIV)
- ☐ Heartburn
- ☐ Swallowing Problems
- ☐ Skin Problems

- ☐ Back Injuries
- ☐ Balance Problem

☐ Other: ____________________________________

**Cancellation policy**

**Thank you for choosing CVMC Rehab services. We look forward to the opportunity to work with you. If you need to cancel your scheduled appointment please call 24 hours in advance. This will enable us to schedule someone else in your place. You can reach us at 371-4242. If we are on the phone with another patient, please leave the date and time of the appointment you wish to cancel, with a brief reason why you are canceling. In the event that you miss more than 2 scheduled appointments we retain the right of canceling your remaining appointments.**

**Please know that we value our relationship with you. Regular attendance and follow through with our recommendations and prescribed home exercise program will help you reach your full rehabilitation potential.**

**Notice of Exclusion from Insurance**

**Some insurances do not pay for supplies, orthotics or iontophoresis. You may be provided a product to bring home and your insurance may only pay a portion of the cost of the product. CVMC will attain all prior authorization, as appropriate, and submit the charges to your insurance company. You will be responsible for paying the whole amount or a portion of the amount that your insurance company does not cover.**

**In signing below, I verify that I have read and understand the above cancellation and Notice of Exclusion from insurance policies and accept responsibility for my active participation in my rehabilitation program.**

**Signature:**______________________________________________________

**Thank you**