TIDELANDS HEALTH NEUROLOGICAL REHABILITATION
MEDICAL HISTORY FORM

Name: _____ Birth Date: _____

Emergency Contact: _____ Cell Phone Number: _____

Referring Physician: _____ Current Height: _____ Current Weight: _____

Past Medical History: *(Please check all that apply and answer questions below)*

__ Osteoarthritis __ HIV / Aids __ Pacemaker __ Diabetes __ Heart Disease
__ MRSA __ Osteoporosis __ Tuberculosis __ Fainting __ Epilepsy
__ High Blood Pressure __ Asthma __ Joint Replacement __ Stroke __ Seizures
__ Pregnancy __ Pneumonia __ Headaches __ Cancer __ Visual/Hearing Impaired
__ Depression

Other History or Details from Selections Above: _____

Previous surgeries: _____

Allergies (list): _____

Current medications: Yes No Please list: _____

_____

Race/Ethnicity: __American Indian __Asian __Black/African American __Caucasian __ Hispanic/Latino __Native Hawaiian __Other

Social History:

Are you currently working? Y N If no, total days missed at work_____ **or** Retired_____
Are your work duties FULL RESTRICTED Number of hours per week you work_____
Who is your employer? _____
What type of work do you do? _____
What critical duties have been most affected by your problem? _____
What type of non-work activities are you involved in?_____
Current living arrangement: __ Private Home __ Assisted Living __ Senior Citizen Home __ Other: _____
Current household occupants: __ Alone __ Spouse __ Children __ Others: _____
Are you a caregiver for any of these occupants: Yes No

Do you have transportation concerns? Yes No

Are you a current smoker or tobacco user? Yes No

Have you recently experienced abuse or neglect? Yes No
(physical, emotional/psychological, neglect, sexual, abandonment, financial/material exploitation, unwarranted control)

Do you have feelings of / or plan to harm yourself or commit suicide? Yes No

Are you being treated by home health services? Yes No

Have you fallen the in past year? Yes No
How many times have you fallen in the past one year? _____
Did you sustain an injury when you fell? If so, please describe: _____
Are you using any assistive devices at this time? No Yes -> __ Cane __ Walker __ Wheelchair

Do you have an Advanced Care Plan? (circle all that apply)

Living Will **Medical Power of Attorney** **DNR**

If you do not have an Advanced Care Plan, would you like more information? Yes No

Name: _____ Birth Date: _____

Reason coming to therapy (body part / problem): _____

What do you hope to achieve from therapy (your goals)? _____

Current surgery: _____ **Date of Surgery:** _____

Who have you seen for this issue: __ Doctor __ Other Therapy __ Chiropractor __ Other: _____
Have you been treated in therapy for this same issue? Yes No

Please circle one: Right Handed Left Handed

Current pain level: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

PLEASE RATE USING THE FOLLOWING SCALE:

1. **CAN DO WITHOUT DIFFICULTY**
2. **CAN DO WITH SOME DIFFICULTY**
3. **CAN DO WITH GREAT DIFFICULTY**
4. **CANNOT DO AT ALL**

Lying down	1	2	3	4	_____
Sitting	1	2	3	4	_____
Standing	1	2	3	4	_____
Walking	1	2	3	4	_____
Jogging/Running	1	2	3	4	_____
Stairs	1	2	3	4	_____
Lifting-Carrying	1	2	3	4	_____
Driving a Car	1	2	3	4	_____
Overhead Reaching	1	2	3	4	_____
Housework	1	2	3	4	_____
Yard Work	1	2	3	4	_____
Dressing	1	2	3	4	_____
Speaking clearly	1	2	3	4	_____
Understanding others	1	2	3	4	_____
Remembering things	1	2	3	4	_____
Finding the right words	1	2	3	4	_____
Eating	1	2	3	4	_____
Drinking liquids	1	2	3	4	_____

Have you lived in or traveled outside of the United States within the past 14 days? Yes No
If yes, where: _____

Consistent attendance for all scheduled appointments is required. Please call ahead if you know that you will be late for an appointment. If you are 15 minutes late, we may have to reschedule your appointment.

If you need to cancel an appointment, please do so at least 24 hours in advance. If you do not show for 3 appointments, or fail to provide at least 24 hours advanced notice for a cancellation 3 times, you may be discharged from therapy services and your physician will be notified.

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy at Tidelands Health Rehabilitation Services, a family member of the Georgetown Memorial, Waccamaw Community Hospital System, or Georgetown Physician Associates, LLC.

Patient Signature: _____ Date_____

[redacted]

About SCHIEx / Notice of Participation

Your doctor or health care provider has become a member of the South Carolina Health Information Exchange ("SCHIEx"). SCHIEx makes it possible for your doctor to share your medical history, including medications, allergies, diagnoses and procedures, with other doctors and health care providers involved in your care. It is a safe and secure network that makes sure your personal health information is available to your doctors and other health care providers when and where it is needed. SCHIEx does *not* keep or store your personal health information. This notice tells you how doctors and other health care providers may use or share your electronic health information and with whom it may be shared.

How your electronic health information may be used or shared

Your privacy and your personal health information are protected by federal and state law. Those federal and state laws also govern the way your personal and electronic health information is used or shared through SCHIEx. Your doctors and other health care providers will use and share your electronic health information with other doctors and health care providers involved in your care through SCHIEx to provide, coordinate or manage your health care and any related services.

We would share your electronic health information, as necessary, through SCHIEx with another doctor who has requested to see your electronic health information to provide care to you. We may share your electronic health information from time-to-time with a doctor or health care provider (i.e. a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by helping with your diagnosis or treatment or with whom you start a new treatment relationship.

Participation in SCHIEX

You may 'opt out' of SCHIEx participation. By opting out , your personal health information will not be shared through SCHIEx.

Important information: Please understand that if you opt out, your personal health information will not be used or shared by **any** doctor or healthcare provider through SCHIEx, except where required by law, which could create a delay in your healthcare provider receiving necessary information for your care.

If you change your mind and wish to have your electronic health information shared through SCHIEx, you may cancel your opt out. To cancel your opt out, you or your personal representative must inform hospital registration staff.