LEE'S SUMMIT MEDICAL CENTER
Outpatient Therapy Services
Attendance guidelines
(816) 282-5985

(You may leave a message 24 hours a day)

Thank you for choosing our clinic as your therapy provider. Please call your insurance company to verify your outpatient therapy benefits if you have any questions or concerns.

CLINIC HOURS: 7:00 am-6:00pm Monday through Friday

TO SCHEDULE APPOINTMENTS: After your first appointment, your therapist will determine a schedule for the remainder of your visits. As a reminder of scheduled appointments, you will be provided an appointment card.

- **If you arrive 10 minutes late for your appointment, you may be asked to reschedule or treatment time will be shortened 10 minutes.**
- **If you are going back to the physician and your therapist anticipates that you will return to therapy, you may schedule one future appointment until you get new order from your physician.**
- **We will only schedule one appointment over the phone to avoid confusion.**
- **If your physician wants you to continue therapy, you have one week to call and schedule, otherwise, your chart will be discharged and sent to Lee's Summit Medical Center, Medical records.**

ATTENDANCE GUIDELINES: We understand there may be situations that prevent you from keeping your appointment, however, in order to accomplish the goals of therapy it is important for you to comply with your schedule. If you are unable to keep your appointment, please notify the department at least 4 hours prior to your schedule time. Below are attendance guidelines.

- **Two cancellations/No shows in a 2-week period: a notice to the patient that they maybe discharged from therapy.**
- **Three cancellations/No shows in a 2-week period: discharged from therapy with therapist notifying physician of reason of discharge.**
- **Worker's Compensation patient: Case Manger will be notified after every Cancel/No show.**

PARTICIPATION: The therapist is a guide to help you on the road to recovery. In the end, what you get out of therapy will depend on what you put into therapy. Therapy is not something that is just done in the clinic. When you learn a new skill you must practice it at home or every appropriate situation. Your continued participation in the therapy program specifically designed for you is essential to recovery.

WHAT SHOULD I WEAR?: Wear clothes and shoes you will be comfortable in as you will be moving around, exercising, and walking. If you are receiving knee or ankle therapy, please wear or bring a pair of shorts with you.

Patient Signature____ Date: __________

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Patient Identification

Lee's Summit Medical Center
Patient Medical History Form

Patient Name:____ Date: ___________________

It is necessary for us to request the following information in order to fully evaluate the condition in which we are treating you. If you have any questions, **please ask your therapist during your evaluation.**

_____ Latex allergy
_____ Tape allergy
_____ Other Allergies (please specify) ____

Please check any current or past medical conditions:

- □ Cancer (Type/Location/Date): _________________________
- □ High Blood Pressure
- □ Heart Disease
- □ Pacemaker
- □ Angina/chest pain
- □ Stroke(date)____________
- □ Headaches
- □ Bronchitis
- □ Kidney
- □ Diabetes
- □ Seizures
- □ Polio
- □ Aneurysm
- □ Rheumatoid Arthritis
- □ Asthma/respiratory problem
- □ Rheumatic Fever
- □ Osteoporosis/Osteopenia
- □ Unexplained weight gain/loss
- □ Other Implanted Device(s): ________________________
- □ Other:_________________

Have you currently experienced any of the following:

- □ A change in your health
- □ Nausea/Vomiting
- □ Fever/Chills/Sweats
- □ Shortness of breath
- □ Numbness or tingling
- □ Changes in appetite
- □ Difficulty swallowing
- □ Changes in bowel or bladder
- □ Urinary tract infection
- □ Dizziness
- □ Respiratory infection
- □ Currently smoke
- □ Other: ________________________

Have you had X-rays, MRI, etc. for this condition? If YES please list:___________________________

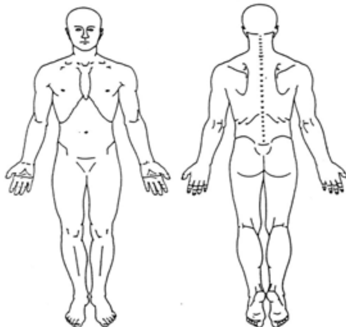
List surgeries with approximate dates in last 10 years: ________________________
____
____
____

List medications/supplements:
____
____
____
____

At Lee's Summit Medical Center, we are concerned about the safety of our patients, so we routinely ask the following:

1. Have you ever been hit, kicked, punched, strangled, threatened, or otherwise hurt by your partner or spouse? **YES NO __**
2. Is your partner or spouse threatening you, or otherwise making you feel afraid? **YES NO __**
3. If yes to either of these questions would you like to speak **confidentially** to a Domestic Violence Advocate? **YES NO NA __**
4. During the past month have you been feeling down, depressed or hopeless? **YES NO __**
5. During the past month have you been bothered by having little pleasure or interest in doing things? **YES NO __**

**On the body diagram below, please indicate and describe where your pain is located.



Therapist Signature: __________________________

Date: _______________ Time: ________________

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Lee's Summit Medical Center
Registration (page 2)

Patient Name: ____
Date:____

Have you experienced any of the following in the last 7 days?
(please circle Yes or No)

Fever greater than 100.4?.. Yes No
Cough? (not related to allergy or COPD)………………………….. Yes No
If yes:
Has the cough been persistent for greater than 3 weeks?.......Yes No
Has the cough produced blood?..Yes No

Sore Throat?..Yes No
Night Sweats?..Yes No
Unexplained Weight Loss?...Yes No
Fatigue?..Yes No
Body Aches?..Yes No
Rash?...Yes No
Nasal Congestion? (not related to allergies or sinus infections)…….Yes No

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Do you have any history of TB or a positive TB skin test?................Yes No
Have you had close contact with a person who has TB?...................Yes No
Have you had close contact with any person having an
Influenza-like illness?………………………………………Yes No

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Patient Identification