



## Outpatient Therapy Services

Dear Future Patient,

Hello, we would like to say 'Thank You,' for choosing Lee's Summit Medical Center Outpatient Therapy Services as your therapy provider. We offer a full spectrum of outpatient physical therapy, occupational/hand therapy, and speech pathology services.

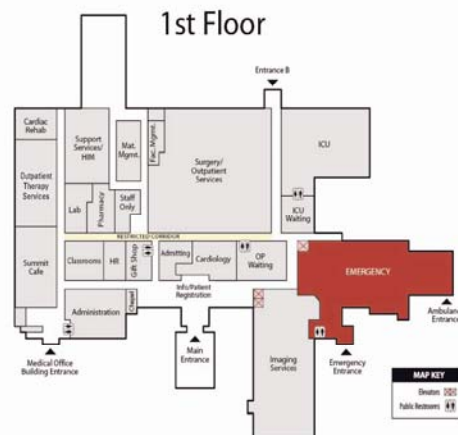
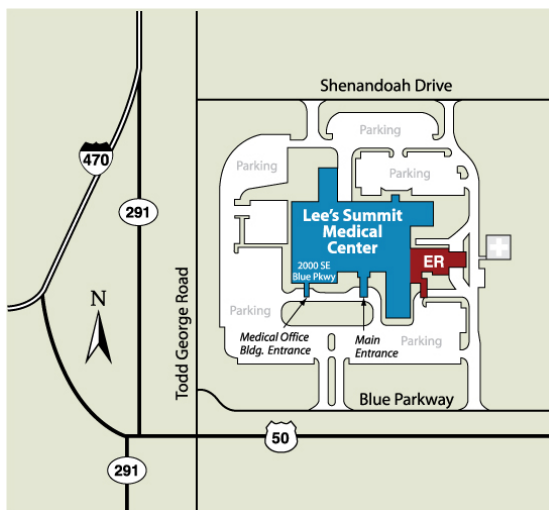
We have developed this packet to make the registration process for therapy more convenient. If able, please fill out the following paperwork that provides us with necessary and important information for your registration and therapy session(s). If you are able to complete the packet, then you may either fax it to us at 816-282-5988 prior to your first appointment or bring it with you for your first therapy session.

If you have any questions regarding the paperwork or your therapy experience, then please call our front office or Gabriel Clements (Director) at 816-282-5985. We look forward to meeting you in person.

Sincerely,

Staff of Outpatient Therapy Services  
Lee's Summit Medical Center

**PS:** Attached you will find a Medical History Form, an Attendance Guidelines Form, and a Bird Flu Form (medical requirement to prevent virus/flu outbreaks). Please complete as able, if unsure then leave blank.



**2100 SE Blue Parkway, Lee's Summit, MO 64063**  
**Phone (816) 282-5985 Fax (816) 282-5988**

**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.

Pt. Signature \_\_\_\_\_

Date: \_\_\_\_\_

# 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:**

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Cancer (Type/Location/Date):<br>_____ | <input type="checkbox"/> Headaches    | <input type="checkbox"/> Rheumatoid Arthritis                |
| <input type="checkbox"/> High Blood Pressure                   | <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Asthma/respiratory problem          |
| <input type="checkbox"/> Heart Disease                         | <input type="checkbox"/> Kidney       | <input type="checkbox"/> Rheumatic Fever                     |
| <input type="checkbox"/> Pacemaker                             | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Osteoporosis/Osteopenia             |
| <input type="checkbox"/> Angina/chest pain                     | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Unexplained weight gain/loss        |
| <input type="checkbox"/> Stroke(date)_____                     | <input type="checkbox"/> Polio        | <input type="checkbox"/> Other Implanted Device(s):<br>_____ |
| <input type="checkbox"/> Aneurysm                              | <input type="checkbox"/> Other: _____ |  |

**Have you currently experienced any of the following:**

- |  |  |
|--|--|
| <input type="checkbox"/> A change in your health | <input type="checkbox"/> Changes in bowel or bladder |
| <input type="checkbox"/> Nausea/Vomiting         | <input type="checkbox"/> Urinary tract infection     |
| <input type="checkbox"/> Fever/Chills/Sweats     | <input type="checkbox"/> Dizziness                   |
| <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Respiratory infection       |
| <input type="checkbox"/> Numbness or tingling    | <input type="checkbox"/> Currently smoke             |
| <input type="checkbox"/> Changes in appetite     | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Difficulty swallowing   |  |

**Have you had any X-rays, MRI, etc? If YES please list:** \_\_\_\_\_

**List surgeries with approximate dates in last 10 years:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

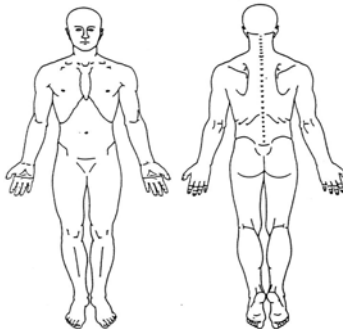
**List medications/supplements:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

Pt Sticker

**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