QUALITY MEDICAL FITNESS
Cardiopulmonary Rehabilitation Department
CARDIAC REHABILITATION PROGRAM
Patient Health Assessment Questionnaire

In order to prescribe the proper rehabilitation program to suit your individual needs, please fill out the following questionnaire regarding your health.

Name: _____
(last) (first) (initial)

Address: _____
(Street Address)

_____
(City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Email Address: _____

Emergency Contact Name, Relation & Phone:

_____

Referring Physician & Phone: _____

Primary Physician & Phone: _____

Insurance: _____ Co-Payment Amount: _____

(due on date of service)

Please briefly state, in your own words, why you were referred to this program: _____

_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?	**YES**	**NO**
Breathless with strenuous exercise		
Short of breath when hurrying on the level or walking up a slight hill		
Walks slower than people of the same age on level ground because of breathlessness, or has to stop for breath when walking at own pace on level ground		
Stops for breath after walking about 100 yards or after a few minutes on level ground		
Too breathless to leave the house or when dressing or undressing		

Quality Medical Fitness
Cardiopulmonary Rehab

389 Fort Salonga Road
Northport, NY 11768
Phone: 631-686-6658
Fax: 631-651-8959

Last Name First Name D.O.B.

Cardiopulmonary Rehabilitation Department

Please make a check in the correct box and explain any "yes" in comment section.

REVIEW OF SYSTEMS	YES	NO	NOT SURE/COMMENTS
HAVE YOU EVER HAD?			
High blood pressure			
Heart attack			
Abnormal EKG			
Chest pain or angina			
Heart valve problem			
Irregular heart beat or palpitations			
"Fluid in the lungs" – congestive heart failure			
Swelling of ankles			
"Balloon procedure" or stent - angioplasty			
Pain in leg(s) when walking or active			
Pacemaker or defibrillator			
Anemia			
Recent cough, cold, fever, chills in the last 2 weeks			
Asthma			
Pneumonia in the last 2 months			
Emphysema			
Shortness of breath when lying down? How many pillows do you use?			
Use oxygen at home? How many liters?			
Loud snoring or sleep apnea			
Use CPAP or BIPAP machine			
Pulmonary embolism (blood clot in the lungs)			
Other lung or breathing problem			
Kidney failure/Hemodialysis/Peritoneal Dialysis			
Liver disease/cirrhosis			
Hepatitis or jaundice			
Transplant of kidney/liver/pancreas			
Heartburn, acid reflux			
Difficulty swallowing or choking on food/drink			
Take diet medications now or in the past			
Recent weight loss of 20lbs or more due to illness			
Ulcerative colitis? Last steroid use?			
Muscle disease			
Stroke or TIA ("mini-stroke")			
Seizures or convulsions			
Hospitalizations in the last year?			
Flu vaccine			
Pneumonia vaccine			
Do you use an assistive device? (e.g. walker, cane, etc.)			
Have you fallen recently? Please explain.			

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REVIEW OF SYSTEMS	YES	NO	NOT SURE/COMMENTS
Do you have pain? Where?			
Does your pain increase with activity?			
Diabetes			
If diabetic, how long?			
Range of morning glucose from low to high			
Insulin?			
Oral medications for diabetes?			
Current or past smoker			
How many packs per day?			
How many years?			
If you quit, when was your quit date?			
If you have not, are you willing to quit?			
Exercise			
What type (swim, bike, walk, etc.)			
How many days per week?			
How long is each exercise session?			
Would you call your exercise light, moderate, or strenuous?			

SURGERIES:

YEAR **SURGERY** **WHERE**

1. _____

2. _____

3. _____

4. _____

What activity of daily living can you no longer perform due to your cardiac disease?

_____

What do you hope to achieve from this cardiac program?

_____

Do you have an Advance Directive or Durable Power of Attorney for Healthcare? Y/N. If yes, is a copy in the system? Y/N.

If no, please provide a copy. If no to the first question, would you like to receive information? _____

Do you have any cultural, spiritual, or religious beliefs that might affect how we treat or teach you? _____

_____

Declaration of Commitment:

I, _____, am willing and motivated to enter Quality Medical Fitness P.C.'s Cardiac Rehabilitation Program, and that I am ready to receive health instruction at this time. This program will include 3 days per week of supervised exercise and Cardiac-related education, which will help me to better manage my heart condition. I am also committed to following the recommended prescribed home exercise program given to me by the Cardiac Rehabilitation clinician. Finally, I am committed to maintain non-smoking status, or, If I am a smoker, I will accept smoking cessation counseling and commit to quitting by the 3rd rehabilitation session.

Signature: _____ **Date: _____**

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PATIENT MEDICATION RECORD

Medication /Allergy History:	
Allergies/Sensitivities (drugs, herbs, foods, dye, latex, tape, etc.)	**Reaction:**

Medication/Drug	**Dose**	**Route**	**Frequency**	**Reason**

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_____

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The Generalized Anxiety Disorder 7 – Item Scale

Today's Date_____

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about difference things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: ☐ **= Add Columns** _____ + _____ + _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
_____	_____	_____	_____

Interpreting the Score:

Total Score	**Interpretation**
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild anxiety
10	Moderate anxiety
15	Severe anxiety

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QUALITY MEDICAL FITNESS

CARDIOPULMONARY REHABILITATION

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Today's Date: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling asleep, staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**
COLUMN TOTALS:		**____ +**	**____ +**	**_____**
ADD TOTALS TOGETHER: _____				

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

□ **Not difficult at all**	□ **Somewhat difficult**	□ **Very difficult**	□ **Extremely difficult**

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Notice of Patient Information Privacy Practices

Legal Duty

Quality Medical Fitness is required to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Quality Medical Fitness uses your personal health information primarily for treatment, obtaining payment for treatment, and evaluating the quality of care that we provide, as well as for internal administrative activities, for example, we may use your personal health information to contact you to provide appointment reminders or to provide you with information about treatment alternatives or other health-related services that could be of benefit to you.

Quality Medical Fitness may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release our information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Quality Medical Fitness may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted and/or you may request an updated copy of our Notice of Patient Information Privacy Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information for reasons other than treatment, payment or other related purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or emergency circumstances.

Concerns and Complaints

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer. You may also send a written complaint to the US Department of Health and Human Services.

I have read and fully understand Quality Medical Fitness's Notice of Patient Information Practices. I understand that Quality Medical Fitness may use or disclose my personal information for the purposes of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Quality Medical Fitness's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature of Patient or Patient's Representative

Date

Patient Name (Print)

If not patient, Relationship to Patient

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Patient Financial Agreement

Keeping the lines of communication open with all of our patients on all matters is a key focus of Quality Medical Fitness. The following are the financial policies and expectations of our office. Please read this section carefully and sign below. If you have any questions, please ask our office staff for clarification.

- Upon arrive to our office, we will verify your insurance coverage. However, it is the responsibility of you, the patient, to be aware of your benefit details. According to all insurance carriers, **VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE OR PAYMENT.** This means that you, the patient or guarantor, are ultimately responsible for the cost of your treatment.

- All visit payments are due before the start of your treatment each visit.

- We do our best to estimate the amount that your insurance plan will apply to your deductible, copay and/or co-insurance or hold you, the patient, responsible for each visit. If your insurance company deems you responsible for an amount that differs from what we estimated, this will be considered your, the patient's responsibility and will be billed to you, the patient.

By signing below, I agree that I have read and understand this patient financial agreement. I agree to company and accept responsibility to the terms outlined above.

Patient Name:_____Signature:_____Date:_____

Witness Name:_____Signature:_____Date:_____