Center for Neurorehabilitation Services - Adaptive Driving Solutions
Client Contact & Insurance Information

Today's Date: ____________________

Client Name:

____
Last First Middle

Client Address:

____
Street City State Zip Code

Client Preferred Phone: ______________________________ (circle one) Cell / Home

Client Email: ____

Age: __________ Date of Birth: _______________ Sex: (circle one) Male / Female

Client Occupation: ______________________________ Marital Status: (circle one) M S D W

Person to contact to schedule appointments:

____
Name Phone #
Relationship

Emergency Contact: ____
Name Phone # Relationship

If Client is a minor, or if the client has a guardian, please fill out the following information about the responsible party:

Name of Responsible Party: ____ Relationship: ____________
(parent, POA, guardian, etc.)

Mailing Address:

____

Phone #: _____________________ Date of Birth: ______________

Occupation: ___________________ Employer: ______________________________ Years Employed: _______

Employer Address: ____ Phone #: __________________

Are calls allowed? (circle one) Yes / No If yes, during what hours? _______________

Type of Insurance to be billed: (circle one)

Worker's Compensation Division of Vocational Rehab Private Pay

Other: ______________________________

CNS Adaptive Driving Solutions

Patient History

Date Completed: ______________

Patient Name: (Last) ______________________ (First) ______________________

Person(s) contributing to this form: ______________________________________

LIVING ENVIRONMENT

Does your home have:

- ☐ Stairs, no railing
- ☐ Stairs with railing
- ☐ Ramps
- ☐ Elevator
- ☐ Uneven terrain
- ☐ Assistive Devices (e.g. bathroom):

  ____
- ☐ Any obstacles:

  ____

Where do you live?

- ☐ Private home
- ☐ Private apartment
- ☐ Rented room
- ☐ Board and care/assisted living/group home
- ☐ Homeless (with or without shelter)
- ☐ Long-term care facility (nursing home)
- ☐ Hospice
- ☐ Other: ______________________________

SOCIAL HISTORY

Employment/Work (Job/School/Play)

Occupation: ______________________________

- ☐ Working full-time outside of home
- ☐ Working part-time outside of home
- ☐ Working full-time from home
- ☐ Working part-time from home
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Unemployed

Do you use:

- ☐ Cane
- ☐ Walker or wheeled walker
- ☐ Manual wheelchair
- ☐ Motorized wheelchair
- ☐ Glasses, hearing aids
- ☐ Other: ______________________________

GENERAL HEALTH STATUS

Please rate your health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes during the past year? If yes, please describe (e.g. new baby, job change, death of a family member) ☐ Yes ☐ No

____

EXERCISE

Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No

If yes, describe the exercise: ______________________

On average, how many days per week do you exercise or do physical activity? __________

For how many minutes, on an average day? __________

MEDICAL/SURGICAL HISTORY
Please check if you have ever had:

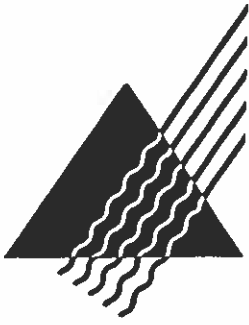
- ☐ Arthritis
- ☐ Broken bones/fractures
- ☐ Osteoporosis
- ☐ Blood disorders
- ☐ Circulation/vascular problems
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Depression
- ☐ Stroke
- ☐ Diabetes/high blood sugar
- ☐ Repeated infections
- ☐ Low blood sugar/hypoglycemia
- ☐ Ulcers/stomach problems
- ☐ Head injury
- ☐ Multiple Sclerosis
- ☐ Muscular dystrophy
- ☐ Kidney problems
- ☐ Parkinson's disease
- ☐ Seizures/epilepsy
- ☐ Allergies
- ☐ Developmental/growth problems
- ☐ Thyroid problems
- ☐ Cancer
- ☐ Infection disease (e.g. tuberculosis, hepatitis)
- ☐ Skin diseases

Within the past year, have you had any of the following symptoms? (check all that apply)

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Dizziness or blackouts
- ☐ Coordination problems
- ☐ Weakness in arms or legs
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Joint pain or swelling
- ☐ Pain at night
- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Nausea/vomiting
- ☐ Difficulty swallowing
- ☐ Bowel problems
- ☐ Weight loss/gain
- ☐ Urinary problems
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Other: ______________________

FUNCTIONAL STATUS/ACTIVITY LEVEL (check all that apply)

- ☐ Difficulty with locomotion/movement
  - ☐ Bed mobility
  - ☐ Transfers (such as moving from bed to chair, from bed to commode)
  - ☐ Gait (walking)
    - ☐ On level ☐ On ramps
    - ☐ On stairs ☐ On uneven terrain
- ☐ Difficulty with self-care (such as bathing, dressing, eating, toileting)
- ☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
- ☐ Difficulty with community and work activities/integration
  - ☐ Work/school
  - ☐ Recreation or play activity



CNS
Adaptive Driving Solutions

Occupational Therapists
and Certified Driving
Rehabilitation Specialists:

Christy Dittmar
MS, OTR/L, CDRS

Denise Kaplan
OTR/L, CDRS

Colleen Knoll
OTR/L, CDRS

NAME: ______________________________ DATE: ____________________

MEDICATIONS

Please list any medications you are currently taking. Use separate sheet of paper if needed.

Medication	mg	# per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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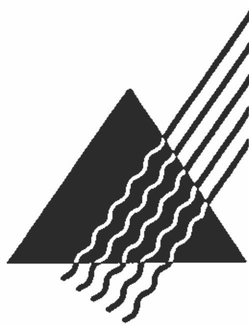

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Individual Consent Form

Consent for the use and disclosure of individually identifiable health information for treatment, payment, and/or healthcare operations

I understand that as a part of my rehabilitation care, the Center for Neurorehabilitation Services (CNS) Adaptive Driving Solutions receives, originates, maintains, discloses and uses individually identifiable health information, including but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans and billing and health insurance information. I understand that CNS and its therapists and staff may use this information for the following purposes:

- Plan my care and treatment
- Communicate with other health professionals concerning my care
- Document services for payment/reimbursement

I consent to the use and disclosure of my individually identifiable health information for treatment, payment and health care operations:

☐ Without restriction.
☐ With the following restriction(s):

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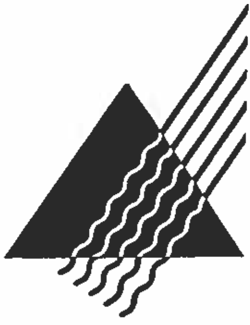

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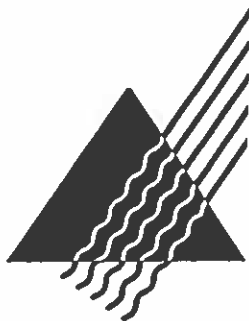
The following is a list of individuals or organizations with whom I would specifically like CNS to exchange written or verbal information, including medical records and reports, related to my evaluation and care:

Name:	Mailing Address:
______________________________	______________________________________
______________________________	______________________________________
______________________________	______________________________________
______________________________	______________________________________
______________________________	______________________________________

Authorizing signature (persons age 18 and older sign for themselves):

Print Client Name	Birth Date	
Signature of Client/Client Representative	Date	Relationship to Client
Witness	Date	

I agree a photocopy of this original consent form is as valid as the original.



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Notice of Privacy Practices Summary

Effective Date 4-14-03

Uses and Disclosures

Treatment: Your health information may be used by staff members of disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, reports will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan or from other sources of coverage, such as an automobile insurer. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of CNS. For example, the information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality of CNS services.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.

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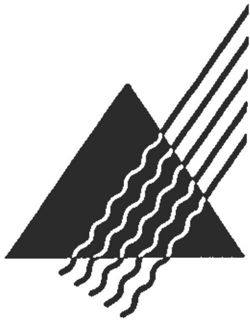

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Acknowledgement of Receipt of Notice of Privacy Practices

The Center for Neurorehabilitation Services (CNS) Adaptive Driving Solutions reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for CNS.

____________________	____________________	________
Name of Client (Print or Type)	Signature of Client	Date

____________________	____________________
Signature of Client Representative	Relationship to Client

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No-Show/Cancellation Policy

Effective 7-1-16

It is important that each of our clients understand the nature of our scheduling. The three occupational therapists in our offices at Littleton and Fort Collins are very busy and schedules run under high demand.

So, it is important for each client to keep any scheduled appointments unless there is an emergency. Our **current cancellation expectation is 24 hours in advance of the appointment,** so that we can try to fill the time with another person. Thank you for respecting that and helping us to communicate accurately with you!

In case of emergency cancellation, please call our main office at 970-493-6667 to tell us the reason for your absence.

In order impress the importance of this communication, we will be charging you a $100 /session cancellation fee. Thank you for understanding that our therapists need to be paid for their time and if you aren't there, we have missed an opportunity to see someone else.

We look forward to seeing you EVERY session!

Christy Dittmar, Denise Kaplan, Colleen Knoll, Kim Dittmar