Welcome to the Hospital of Central Connecticut Rehabilitation Network. We thank you for choosing us, and we will strive to exceed your expectations and overall results.

During your first visit you will receive a comprehensive evaluation by a licensed Physical, Occupational or Speech Therapist. Your therapist will work with you to identify your functional deficits, from which specific goals will be set. An individual treatment plan will be created specifically for you.

Please keep in mind:

- You are responsible for determining the limits of outpatient rehabilitation benefits and for obtaining any required referral forms. Authorization does not constitute guaranteed payment of charges. The patient is ultimately responsible for any charges and co-pays.

- If you are late for an appointment, we may have to reschedule or shorten your treatment time. If you are unable to attend your appointment, please call 24 hours prior to your appointment.

- **TWO CANCELLATIONS OR NO-SHOW APPOINTMENTS WILL RESULT IN DISCHARGE FROM THE THERAPY PROGRAM.** By scheduling appointments and not attending, it limits the availability for our other patients in need of appointments. In addition, it will interfere with your ability to maximize your results with therapy. You will be required to obtain a new order from the referring physician prior to any future appointments being scheduled.

I understand the above information and am in agreement with this program:

Patient Signature ___________________________________________ Date _________________________

We value your feedback, so if at any time you would like to share your comments or concerns, please do not hesitate to contact me directly.

Robert Stair PT, MBA, Cert MDT
Director
HOCC Rehabilitation Network
Occupational Health Network
Phone: 860-224-5121
Email: robert.stair@hhchealth.org
## Past Medical History

Patient Name: _____________________________  
Date of Birth: __________________  
Date: _____________

Cell #: ______________  
Carrier (Verizon, Sprint, etc.): ____________  
Appt. Reminders? Text / Email / Call

Primary Care Physician: ________________  
PCP phone number: ________________

E-Mail: ___________________________  
Ebola Screened by: ________________

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>YES</th>
<th>NO</th>
<th>In the past 3 months, have you had?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>A change in health</td>
<td></td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td>Nausea/Vomiting</td>
<td></td>
<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td>Fever/Chills/Sweats</td>
<td></td>
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<tr>
<td>Cancer</td>
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<td></td>
<td>Unexplained weight change</td>
<td></td>
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<tr>
<td>Seizures</td>
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<td></td>
<td>Numbness or tingling</td>
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<tr>
<td>Allergies</td>
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<td>Change in appetite</td>
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<td>Stroke</td>
<td></td>
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<td>Difficulty swallowing</td>
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<tr>
<td>Arthritis</td>
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<td></td>
<td>Changes in bowel/bladder</td>
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<tr>
<td>Osteoporosis</td>
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<td></td>
<td>Upper respiratory infection</td>
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<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td>Shortness of breath</td>
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<tr>
<td>Pain at night</td>
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<td></td>
<td>Dizziness</td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you currently pregnant?  YES  NO  
If “yes”, when is your due date? ________________

Operations/broken bones/other medical problems:  YES  NO  
If yes, please list ____________________________________________  
________________________________________________________________
________________________________________________________________

Are you taking any medications:  YES  NO  
If yes, please list ____________________________________________  
________________________________________________________________
________________________________________________________________

Do you have any allergies:  YES  NO  
If yes, please list ____________________________________________  
________________________________________________________________
________________________________________________________________

In case of an emergency please notify:  
Name: ___________________________  
DOB: ___________________________  
Address: ___________________________  
Relationship to: ___________________________  
Phone: ___________________________