STROWMATT REHABILITATION SERVICES, INC
11020 KATY FREEWAY, STE. 217, HOUSTON, TX 77043
PHONE (713) 722-0667 FAX (713) 722-0669 strowmattrehabservices@gmail.com

# SRS – CLIENT PRE-APPOINTMENT QUESTIONNAIRE

**PLEASE SKIP OVER OR ANSWER "N/A" IF A QUESTION DOES NOT PERTAIN TO YOUR INDIVIDUAL SITUATION**

Client Name: _____ Date: _____
Home Phone:_____ Email:_____
Cell Phone:_____ Address: _____
Alt Phone: _____ _____
DOB: _____ Gender: Male___ Female ___ Height: _____ Weight: _____ Lbs.

1. What is your Medical Condition/Diagnosis? _____
   A) If Spinal Cord Injury, what level?_____ When was this diagnosis made? _____
2. Are you currently being treated for this medical condition? ___Yes ___ No; Please list any medications you are currently taking. _____
   _____
3. Have you had a seizure in the last 6 months? ___Yes ___ No; If yes, date of seizure_____
4. Do you have a current driver's license or learner's permit that allows you to be evaluated on public streets? ___Yes ___ No; If not, has your license been suspended/revoked or turned into the Medical Advisory Board? ___Yes ___ No;
   ***NOTE: WE WILL NOT SCHEDULE AN APPOINTMENT UNTIL A PERMIT OR LICENSE HAS BEEN OBTAINED***
5. Do you currently drive? ___Yes ___ No; If not, when was the last time you drove? _____
6. How many miles per year do you typically drive? _____ miles per year
7. Do you currently use special equipment/have modifications? ___Yes ___ No; If yes, List the brand name and configuration of the equipment: _____
8. Do you have any visual deficits? ___Yes ___ No; If yes, please be specific. _____
9. Do you have double vision? ___Yes ___ No;
10. Have you been diagnosed with homonymous hemianopsia? ___Yes ___ No;
    If yes, please provide Humphrey's Field Analysis, if available.
11. Do you have any endurance issues that we need to be aware of? ___Yes ___ No; _____
12. Do you have good control of your arms? ___Yes ___ No; Legs? ___Yes ___ No;
13. Is one side of your body, i.e. arm or leg, stronger than the other?
    ____ left arm ____ right arm
    ____ left leg ____ right leg
14. Is your strength good in your hands? ___Yes ___ No; Shoulders? ___Yes ___ No;
15. Can you walk? ___Yes ___ No; If so, how far can you walk at one time? _____
16. Do you use a wheelchair? ___Yes ___ No; Is it a Manual chair ___, or Power chair ___?
17. What is the brand name of the wheelchair? _____
18. Do you have a 3 or 4-wheeled scooter? ___Yes ___ No; Type/Brand _____

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19. Have you been to our office before? ___Yes ___ No

20. Can you transfer from wheelchair/scooter to the driver's seat? ___Yes ___ No;

21. Does the transfer have to be level surface? ___Yes ___ No;

22. Can you get in/out of a **SUV/Truck** independently? ___Yes ___ No;

23. Is this evaluation due to your vehicle needing *modification updates*? ___Yes ___ No;

24. What type of vehicle do you want to drive? ___ Car, ___ SUV or ___ Van (select one or more)

25. What type of equipment do you think you need? _____

26. Do you think you can use the standard steering wheel? ___Yes ___ No;

27. If not, do you think you can use a horizontal steering wheel? ___Yes ___ No;

28. Do you need mechanical hand controls? ___Yes ___ No; Which side?
A) Are you Right-hand_____ Left-hand _____ dominate?

29. Do you need a left foot accelerator? ___Yes ___ No;

30. Our hours of operation are generally Monday-Friday 8am to 5pm. Are there any scheduling restrictions or preferences you have? _____

## FUNDING SOURCE - YOU MUST SELECT ONE OF THE OPTIONS BELOW:

A) **Self Pay** _____ **SRS DOES NOT FILE HEALTH INSURANCE.** Private health insurance requires payment at time of services before filing for reimbursement.

B) **Worker's Comp** _____ For Worker's comp and VA, **SRS REQUIRES PRE-PAYMENT**
*Case Manager:*_____ *Phone:* _____
*Email:*_____ *Fax:* _____

C) **TWC/HCIL/ILS** _____ Vocational Rehab 3rd Party. **We will send a quote to your counselor.**
**LRS/OK-VOC** *Counselor:*_____ *Phone:* _____
(Circle One) *Email:*_____ *Field Office:*_____

**Strowmatt Rehabilitation Services Inc. (SRS) in a private practice Occupational Therapy Facility that is also licensed as a TDLR approved Driving School. As such, we need a physician's referral (for OT licensing purposes), a valid license or permit (to properly evaluate the driver on public streets), and a pre-approved financial coverage. This questionnaire will help us establish your basic functional level and customize the evaluation and training program for you. Thank you for your assistance in this matter. Call if you have any questions.**

**CANCELLATION/NO SHOW POLICY:** Strowmatt Rehabilitation Services, Inc. (SRS) requires 24-hour notice for cancellation of a scheduled appointment. Failure to do so may result in a partial charge of the scheduled services. We do understand that there are extenuating circumstances that occur and we will take them into consideration on a case-by-case basis, as warranted.

**REFUND POLICY:** Strowmatt Rehabilitation Services, Inc. (SRS) states that if fees are collected in advance of entrance and if the consumer does not complete the training, terminates enrollment or withdraws, the school (a) may retain not more than $50.00 in administrative fees; and (b) shall refund that portion of instruction fees that correspond to the service the consumer does not receive. Refunds shall be completed within 30 days of the effective date of termination.

**COMPLAINTS**: Any grievances not resolved by SRS may be forwarded to Texas Department of Licensing and Regulation Attention: Enforcement Division PO Box 12157, Austin, TX 78711; 800-803-9202 www.tdlr.texas.gov/complaints.

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# SRS - DRIVER CONSENT FORM

**THIS FORM MUST BE COMPLETED, SIGNED AND RETURNED TO SRS STAFF BEFORE AN APPOINTMENT WILL BE SCHEDULED**

1.) I, _____, agree to undergo a comprehensive driver evaluation, and possible training, by the staff of Strowmatt Rehabilitation Services, Inc., (hereinafter referred to as SRS), for the purpose of determining my ability to safely operate a motor vehicle. I consent and agree to participate in all of the evaluation procedures that SRS feels appropriate in determining my ability to drive safely.

2.) I understand that operating a motor vehicle on public roads is a privilege, not a right, granted to me by the State of Texas and its Department of Public Safety. The Texas DPS has its own laws and regulations concerning operation of motor vehicles. I further understand that the program may not provide training in all areas of motor vehicle operations and that I am solely responsible for the safe operation of motor vehicles in accordance with all applicable laws and regulations when I am behind the wheel of any and all motor vehicles I operate.

3.) I understand that safely operating a motor vehicle requires good physical control of the vehicle, as well as good visual, perceptual and cognitive skills by the driver in order to react to ever-changing surroundings and the driving environment. I understand that my medical diagnosis may impair my driving ability, thus my participation in this driver evaluation/training/education program presents risks to me such as, but not limited to, my involvement in a motor vehicle accident. I voluntarily assume these risks and will not hold SRS liable for any incidents in which my individual actions could cause harm to myself or others.

4.) I consent to allow SRS to inform my referring physician(s) and any 3rd party payor of the results of this evaluation and any and all subsequent training. My referring physician and the SRS staff will also inform the Texas Department of Public Safety of the results of my evaluation/training should it be deemed appropriate for safety concerns to the community or myself, and when required by law to do so. I give my consent to all such disclosures with an awareness that such disclosures may result in the suspension or revocation of my license to drive or prevent me from obtaining a license to drive in the future.

5.) I understand the authority to revoke or suspend or effect my license in any way rests solely upon the Texas Department of Public Safety. It is ultimately the Texas Department of Public Safety who determines my licensing status.

6.) I certify I have provided the SRS staff with the most up-to-date and accurate medical history available.

7.) I agree to abide by the recommendations given by the SRS staff upon completion of the comprehensive driver assessment and or training. These recommendations may include vehicle and adaptive equipment requirements, a series of driver education or training lessons, a request for further medical consultation or therapies to determine whether additional treatment is necessary, or a report to my referring physician or Texas Department of Public Safety recommending revocation or suspension of my license as deemed appropriate. I agree to cease driving immediately if the SRS staff believe it is unsafe for me to continue driving.

8.) I am solely responsible for adhering to and accomplishing all SRS staff recommended actions and understand that documentation of my ability to drive a motor vehicle will be contingent upon my completion of all such recommendations within the time perimeters and/or expiration dates given.

9.) Each evaluation or training session will be paid upon completion and or billed to a 3rd party paying source according to SRS procedures. I understand that SRS does not in any way bill insurance and that I am solely responsible for any and all of the bills not paid by my agreed upon 3rd party payor, IF APPLICABLE. The evaluation fee is $200.00 per hour. The training fee is $200.00 per hour, unless stated otherwise on my individual quote. Travel charges including but not limited to, mileage, per diem and lodging may or may not be required for my appointment/lesson to take place. However, all fees will be stated in writing prior to my appointment being scheduled.

10.) I give permission to be photographed and/or videotaped during my session as the SRS staff sees fit for educational and/or documentation purposes, if applicable.

11.) I release and hold harmless the SRS staff, their agents, employees, contractors and support staff from any and all claims arising out of my participation in this driver evaluation/training program. I further understand that the driver trainers, therapists and/or staff of SRS may, in their professional judgement, terminate my participation in this program at any given time.

12.) I agree to contact the Driver Program immediately should there be any change in my condition that affects my ability to drive.

_____ _____

Patient Signature: Date Signed:

(Instructor to Sign During Intake Appt.)

_____ _____

SRS Instructor Signature: Intake Date Signed: