UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
MEDICAL CENTER

Rehabilitation Services Department
301 Hospital Drive
Glen Burnie, MD 21061
www.mybwmc.org
Phone # 410-787-4433
Fax # 410-595-1983

APPOINTMENT CONFIRMATION

PATIENT NAME: _____

LOCATION: Physical Therapy/Rehab, Lower Level

DATE: _____ **TIME:** _____

Dear Patient,

We are pleased to welcome you as a patient to the Rehabilitation Services Department at UM Baltimore Washington Medical Center. We specialize in Physical therapy, Occupational therapy and Speech Language Pathology and are dedicated to helping our patients and their families to help themselves.

In order to deliver excellent, customized services, **please complete and bring the attached paperwork to your appointment.** You may also fax or drop off these forms to our office before your visit.

On the day of your appointment please bring a **Photo ID, insurance cards and the prescription or referral from your ordering doctor.**

Free valet parking is available to all patients at the main entrance of the hospital. Patient parking is available in the parking garage located to the right of the main entrance.

Please check in at the front desk in the main lobby and inform the receptionist that you are here for your Rehab appointment. The receptionist will call our department and someone will meet you in the lobby to escort you. If you already know where Rehabilitation Services is located, you may come directly to the department.

Please arrive 15 minutes before your first appointment time to fill out additional paperwork. You will receive a reminder call the night before your appointment. Please do not hesitate to call us with any questions or concerns. We look forward to meeting you. Thank you for choosing UM Baltimore Washington Medical Center!

Sincerely,
The Rehabilitation Services Department

UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
MEDICAL CENTER

Rehabilitation Services
New Patient History & Pain Form

Name:_____Date of Birth:_____

Date injury/illness began:_____Date of Surgery: _____

What Previous treatment have you had for this injury/illness: _____

Who do you live with? _____

How many steps do you have at home? _____ Are there railings to use? ☐ Yes ☐ No One or Two?_____

PRIOR LEVEL OF FUNCTION

Occupation: _____ **Hobbies/Sports:** _____

Mobility: *Please indicate if you were independent in or if you need assistance for each task prior to this recent injury/illness. Also, list any device you needed to complete these tasks (i.e. walker, cane, reacher, etc).*

Wheelchair Mobility	☐ Independent	☐ Needed Assistance	Device:
Walking	☐ Independent	☐ Needed Assistance	Device:
Dressing	☐ Independent	☐ Needed Assistance	Device:
Bathing	☐ Independent	☐ Needed Assistance	Device:
Stair Climbing	☐ Independent	☐ Needed Assistance	Device:

GOALS

What specific activities are you unable to do now that you were able to do before this injury/illness? _____

_____

What do you expect therapy to do for you in relation to these activities? _____

_____

MEDICAL HISTORY

Please Circle and Date any conditions you have or have had:

Allergies _____ Asthma _____ Broken Bones _____where:_____

Diabetes _____ Dizziness _____ Change in bowel habits _____

Cancer _____ Excess Stress _____ Change in bladder habits _____

Heart Attack _____ Heart Disease _____ Low Blood Pressure _____

Lung Disease _____ Pacemaker _____ High Blood Pressure _____

Epilepsy/Seizures_____ Recent Weight Loss_____ Chance of Pregnancy now_____

PLEASE LIST ANY SURGERIES YOU HAVE HAD, WITH APPROXIMATE DATES:

SURGERY	DATE

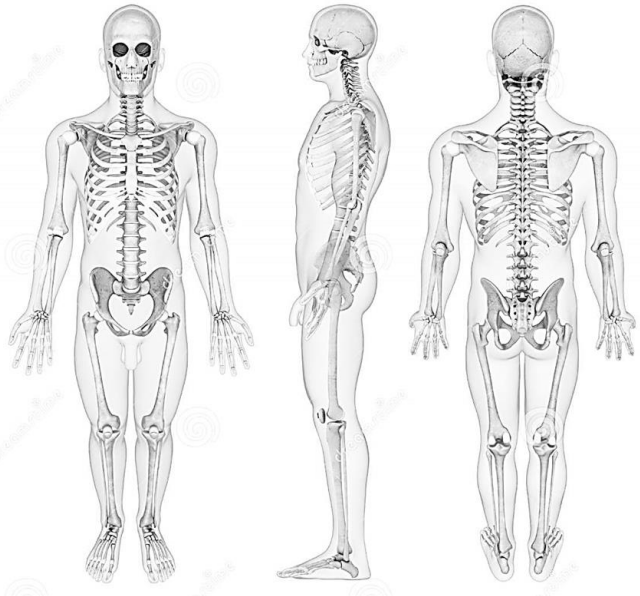
CURRENT MEDICATIONS: _____

_____

UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
MEDICAL CENTER

Rehabilitation Services
New Patient History & Pain Form

Name:_____DOB:_____



Please shade in the area of your pain on diagram and place an "X" over any area(s) of specific pain.

PAIN LEVEL

Please rate the level of your primary pain on a scale of 0 (no pain) to 10 (worst pain imaginable) for each of the following:

Severity of Pain now: 0 1 2 3 4 5 6 7 8 9 10
Severity of Pain at worst: 0 1 2 3 4 5 6 7 8 9 10
Severity of Pain at best: 0 1 2 3 4 5 6 7 8 9 10

PAIN DESCRIPTION

☐ Burning ☐ Tingling ☐ Throbbing ☐ Sharp ☐ Dull
☐ Stabbing ☐ Numb ☐ Brief ☐ Pins/needles ☐ Aching
☐ Constant ☐ Intermittent/Periodic ☐ Other: _____

Was there a specific reason or action that caused your pain to begin? _____

Where was the pain when it first started? _____

Has it gotten better, worse or stayed the same? _____

Has the pain moved or spread since it started? ☐ Yes ☐ No Where? _____

What starts your pain or makes it worse? _____

What stops your pain or makes it better? _____

How is your pain in the morning, evening and during sleep? _____

_____

Separately describe how walking, sitting and standing affect your pain. Do these activities make your pain better or worse or is there no change? _____

_____

Have you had this pain before? ☐ Yes ☐ No If so, when? _____ What did you do for it? _____

_____