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
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).

<table>
<thead>
<tr>
<th>Task</th>
<th>Independent</th>
<th>Needed Assistance</th>
<th>Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair Mobility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
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<td>Dressing</td>
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<tr>
<td>Bathing</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Stair Climbing</td>
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</tbody>
</table>

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  
- Asthma  
- Broken Bones  
- 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:

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>DATE</th>
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CURRENT MEDICATIONS:  

__________________________________________________________________________________

__________________________________________________________________________________
Rehabilitation Services
New Patient History & Pain Form

Name: ___________________________ DOB: ___________________________

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? ________________________________________________________________

____________________________________________________________________________________________________

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

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