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ARTHRITIS &  
REHABILITATION  
THERAPY  
SERVICES

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A COMPREHENSIVE REHABILITATION CENTER

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*A Division of Arthritis  
and Rheumatism Associates, P.C.*

Dear New Patient,

Welcome to Arthritis and Rehabilitation Therapy Services. We are glad that you and your physician have entrusted your physical therapy care to us, and we look forward to helping you achieve your goals.

Enclosed, you will find forms related to your medical history, insurance information and demographics. Please complete the forms in advance and bring them with you to your Initial Evaluation appointment.

Cancellation or "no show" of ANY appointment is subject to a \$50.00 fee, if notice is not provided at least 24 business hours prior to the appointment. If you are unable to make your first appointment, you may be asked to reschedule the full sequence of visits, as your first visit requires more time than subsequent visits. If you are more than fifteen (15) minutes late to ANY appointments, please be advised that your visit may be canceled or limited, in order to adequately accommodate other patients and the therapist's schedule. In order to achieve the best results with therapy, we kindly ask that you make a concerted effort to keep your appointments and to be on time.

For your first appointment, please remember to:

- Bring your updated insurance cards (s).
- Bring your referral from your physician. If you do not have a referral, you may be asked to reschedule your visit.
- Be prepared to pay any applicable co-pays. Please check with your insurance company prior to your first visit.
- Inform the receptionist and therapist if you have any metal implants; i.e.: pacemaker, joint replacement, etc.
- Wear comfortable clothing and shoes. Please make sure that the body part to be treated is accessible.
- Bring a translator if you do not speak English.
- Children are absolutely NOT ALLOWED in the treatment area.
- Cell phone use is not permitted in the clinic.

We look forward to seeing you at your Initial Evaluation.

Sincerely,  
Matthew Reed, MPT & Joshua Costa, DPT  
Executive Directors of Rehabilitation

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CENTRAL CALL CENTER: **301.942.7600**

**[www.washingtonarthritis.com](http://www.washingtonarthritis.com)**

2730 University Blvd. West  
Suite 714  
Wheaton, MD 20902  
TEL 301.942.2520  
FAX 301.942.6998

14995 Shady Grove Rd.  
Suite 320  
Rockville, MD 20850  
TEL 301.929.4125  
FAX 301.251.0495

5454 Wisconsin Ave.  
Suite 620  
Chevy Chase, MD 20815  
TEL 240.482.3680  
FAX 301.652.0210

2021 K St., NW  
Suite 310  
Washington, DC 20006  
TEL 202.293.9412  
FAX 202.912.8462



**ARTS MEDICAL HISTORY**

**Patient Name:** \_\_\_\_\_

*A Division of Arthritis  
and Rheumatism Associates, P.C.*

**Patient DOB:** \_\_\_\_\_

		COMMENTS	P.T. Use
1. Do you have a pacemaker or an electronic implant?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U, E
2. Have you been diagnosed with a carotid sinus or cervical ganglia?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U
3. Have you been diagnosed with a cardiac or pulmonary disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>		T, E
4. Do you have a history of decreased circulation or vascular insufficiency?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U, T
5. Do you have a history of a Deep Vein Thrombosis (DVT)?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U
6. Do you have a history of a Thrombophlebitis?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U
7. Do you currently have active bleeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U, E
8. Have you been diagnosed with an Aortic Aneurysm?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
9. Have you ever been diagnosed with Phlebitis?	Yes <input type="checkbox"/> No <input type="checkbox"/>		E
10. Do you have a history or diagnosis of Meningitis?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
11. Have you ever been diagnosed with a Seizure Disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>		E
12. Do you have a history of Cancer or Tumors?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U, T, E
13. Do you have a history of decreased sensation in any part of your body?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U
14. Have you ever been diagnosed with osteomyelitis?	Yes <input type="checkbox"/> No <input type="checkbox"/>		E
15. Have you recently suffered a sprain, strain, fracture, subluxation, dislocation or inflammation?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
16. Have you been diagnosed with Rheumatoid Arthritis?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
17. Have you ever had a spinal surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
18. Have you ever been diagnosed with Spondylolistheses?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
19. Do you currently have Temporomandibular/Jaw pain?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
20. Have you ever been diagnosed with vertebral instability?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
21. Have you ever been diagnosed with a bone or joint disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
22. Do you have a history of a Hiatal Hernia?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
23. Do you have a history of Osteoporosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>		T
24. Are you currently pregnant or do you plan on becoming pregnant while in physical therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U, T, E
25. Do you have any superficial implants?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U, E
26. Do you currently have an infection?	Yes <input type="checkbox"/> No <input type="checkbox"/>		U
27. Other relevant medical history? Add comments	Yes <input type="checkbox"/> No <input type="checkbox"/>		