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

ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

Arise Infusion Therapy Services
Arthritis and Rehabilitation Therapy Services
Medical Cannabis Institute
Osteoporosis Assessment Center

DIVISIONS OF ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C

MDHAQ

DATE: ____________________ **Primary Care Physician:** ____________________

NAME: ____________________ **Date of Birth:** ____________________

Email Address: ____________________ **Preferred Contact Method:** ____________________

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.

Please check (✓) the **ONE** best answer for your abilities at this time:

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3
Get a good night's sleep?	☐ 0	☐ 1	☐ 2	☐ 3
Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

2. Pain Scale

How much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

NO PAIN ○ **PAIN AS BAD AS IT COULD BE**

0 0.5 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. Patient Status

Considering all the ways in which illness and health condition may affect you at this time, please indicate below how you are doing:

VERY WELL ○ **VERY POORLY**

0 0.5 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

4. Skilled Nursing Facility

Are you currently staying in a skilled nursing facility? Yes ☐ No ☐

5. Home Health Care Services

Are you currently receiving Home Health Care Services? Yes ☐ No ☐

ARTHRITIS & REHABILITATION THERAPY SERVICES

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

A COMPREHENSIVE REHABILITATION CENTER

ARTS MEDICAL HISTORY

Patient Name: ___________________________________

Patient DOB: ___________________________________

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