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# ARTHRITIS & REHABILITATION THERAPY SERVICES

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A COMPREHENSIVE REHABILITATION CENTER

*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

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

## 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<br>ANY<br>difficulty | With<br>SOME<br>difficulty | With<br>MUCH<br>difficulty | UNABLE<br>to do            |
|--------------------------------------------------------------|------------------------------|----------------------------|----------------------------|----------------------------|
| Dress yourself, including tying shoelaces and doing buttons? | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Get in and out of bed?                                       | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Lift a full cup or glass to your mouth?                      | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Walk outdoors on flat ground?                                | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Wash and dry your entire body?                               | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Bend down to pick up clothing from the floor?                | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Turn regular faucets on and off?                             | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Get in and out of a car, bus, train, or airplane?            | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Walk two miles?                                              | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Participate in sports and games as you would like?           | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Get a good night's sleep?                                    | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Deal with feelings of anxiety or being nervous?              | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Deal with feelings of depression or feeling blue?            | <input type="checkbox"/> 0   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 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** ○ 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 **PAIN AS BAD AS IT COULD BE**

### 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** ○ 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 **VERY POORLY**

### 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 ☐

## ARTS MEDICAL HISTORY

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

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

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

|                                                                                                      |                                                          | COMMENTS | P.T.<br>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"/> |          |             |