UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Outpatient Rehabilitation Department

Dear

You have been referred to our office for an outpatient (Occupational Therapy, Physical Therapy, Speech Therapy) evaluation on _____ at _____. Please arrive 15 minutes early to allow time for parking, and completion of registration. We ask that you please provide your prescription, one form of identification, and your insurance card. Please be sure to fill out the attached form as completely as possible BEFORE your visit, to assist with the accuracy and timeliness of your initial evaluation(s). We are located at Suite 514 in the Physicians Pavilion II at 500 Upper Chesapeake Drive. Parking is available in the parking garage, with the first 90 minutes at no cost. Our suite is in the building above the garage. If you have any questions, please feel free to contact our department at 443-643-3257 or 443-643-3258.

Thank you and we look forward to working with you.

Outpatient Rehabilitation Department
Suite 514, Physicians Pavilion II
University of Maryland Upper Chesapeake Medical Center
Bel Air, MD 21014

Check Your Risk for Falling

Please circle "Yes" or "No" for each statement below.			Why it matters.
Yes (2)	No (0)	I have fallen in the last 6 months.	People who have fallen once are more likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light headed or more tired than usual.	Side effects from medicines can sometime increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total_____		Add up the number for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. *J Safety Res;* 2011:42(6)493-499). Adapted with permission of the authors.

Date of Birth: _____/_____/_____

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Outpatient Rehabilitative Services

History Survey

Name:_____

Date of Birth: _____/_____/_____

If you need a form in Spanish, please, let us know. Si usted necesita un formulario en español, por favor, háganoslo saber.

Are you able to understand, read and write in English? If NO, what is your preferred language?

_____

Please take a few minutes to complete this Health Status Survey. Your responses will give us very valuable information regarding your overall health, and will help us take better care of you. If you need help filling out this form, please let us know. Thank you.

Name & address of referring physician:

_____

_____

Will this doctor be following you? ☐ YES ☐ NO - If no, who will be?

_____

_____

Name & address of primary physician (PCP or GP):
Would you like for us to send our reports to them as well? ☐ YES ☐ NO

_____

_____

Please list the name & address of any other doctor(s) that you would like to receive a copy of your report:

_____

_____

Name:_____ Date of Birth: _____/_____/_____

1. Current Condition(s) Chief Complaint(s)

a) Describe the symptom(s) for which you seek therapy:_____

_____

b) When did the symptom(s) start (date)? _____/_____/_____

c) Have you ever had the symptom(s) before? ☐ NO ☐ YES

What did you do for the symptom(s)?_____

_____

Did the symptom(s) get better? ☐ NO ☐ YES

d) What makes the symptom(s) better?_____

_____

e) What makes the symptom(s) worse?_____

_____

f) What are your goals for therapy?_____

_____

g) Are you seeing anyone else for the symptom(s)? Check all that apply:

☐ Acupuncturist	☐ Massage Therapist	☐ Osteopathic Physician
☐ Cardiologist	☐ Neurologist	☐ Pediatrician
☐ Chiropractor	☐ Obstetrician/Gynecologist	☐ Podiatrist
☐ Dentist	☐ Orthopedist	☐ Primary Care Physician
☐ Family Practitioner	☐ Nurse Practitioner	☐ Rheumatologist
☐ Internist	☐ Surgeon	☐ Other:_____

2. Allergies

a) Do you have any known allergies?
☐ NO ☐ YES: Please list them (i.e. Latex): _____

_____

Name:_____ Date of Birth: _____/_____/_____

3. Clinical Tests: Within the past year, have you had any of the following tests?

Check all the apply:

- ☐ Anglogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood Tests
- ☐ Bone Scan
- ☐ CT Scan
- ☐ Doppler Ultrasound
- ☐ Echocardiogram
- ☐ EEG
- ☐ EKG (Electrocardiogram)
- ☐ EMG (Electromyogram)
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve Conduction Velocity
- ☐ Pulmonary Function Test
- ☐ Spinal Tap
- ☐ Stress Test (e.g. treadmill)
- ☐ X-rays
- ☐ Other:_____

4. Medical History

a) Have you ever had? Check all that apply:

- ☐ Arthritis
- ☐ Cancer
- ☐ Muscular Dys.
- ☐ Parkinson's
- ☐ Seizures/Epilepsy
- ☐ Allergies
- ☐ Developmental/growth problems
- ☐ Infectious Disease (e.g., tuberculosis, hepatitis)
- ☐ Circulation/Vascular Problems
- ☐ Diabetes/High Blood Sugar
- ☐ Broken Bones/Fractures
- ☐ Osteoporosis
- ☐ Kidney Problems
- ☐ Repeated Infections
- ☐ Ulcers/Stomach Problems
- ☐ Skin Diseases
- ☐ Thyroid Problems
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Stroke
- ☐ Depression
- ☐ Blood Disorders
- ☐ Multiple Sclerosis
- ☐ Hypoglycemia/Low Blood Sugar
- ☐ Other:_____

b) Within the past year, have you had any of the following symptoms? Check all that apply:

- ☐ Chest Pain
- ☐ Hearth Palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of Breath
- ☐ Dizziness/Blackouts
- ☐ Nausea/Vomiting
- ☐ Weakness in Arms or Legs
- ☐ Loss of Balance
- ☐ Difficulty Walking
- ☐ Joint Pain or Swelling
- ☐ Pain at night
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Vision Problems
- ☐ Bowel Problems
- ☐ Weight Loss/Gain
- ☐ Urinary Problems
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Coordination Problems
- ☐ Difficulty Swallowing
- ☐ Other:_____

Name:_____ Date of Birth: _____/_____/_____

c) Have you ever had surgery? ☐ NO ☐ YES: Please list them and include approximate dates.

_____Date: _____/_____

_____Date: _____/_____

_____Date: _____/_____

5. General Health Status

a) Please rate your health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

b) Have you had any major life changes during the past year? (e.g. new baby, job change, death of a loved one)

☐ NO ☐ YES

6. Social/Health Habits

a) Smoking: Do you currently smoke tobacco? ☐ NO ☐ YES

Cigarettes,_____packs per day. Cigars/Pipes,_____per day.

Have you smoked in the past? ☐ NO ☐ YES Year quit_____

b) Alcohol: How many days a week do you drink beer, wine or spirits?_____

How many drinks do you have on one average day?_____

c) Exercise: Do you exercise beyond normal daily activities and chores?

☐ NO ☐ YES

If YES, how many days a week, on average, do you exercise?_____

How many minutes on an average day?_____

7. Social History

a) Cultural/Religious: Are there any customs or religious beliefs that might affect care?

Please explain:_____

_____

Name:_____ Date of Birth: _____/_____/_____

8. Advanced Directives

a) Generally patients that would experience a medical emergency in outpatient rehab are treated as a full code.

b) Only patients with MIEMSS (Maryland Institute for Emergency Medical Services Systems) protocol or MOLST (Maryland Medical Orders for Life Sustaining Treatment) documentation on their person will be treated as indicated in those orders (may be incorporated into a bracelet or necklace).

c) If you have questions concerning Advanced Directives, please talk to your therapist. We can provide you with information or refer you to Guest Services for further assistance.

9. What is your preferred learning style? (select all that apply)

☐ Verbal Instructions

☐ Written Instructions

☐ Demonstration

☐ Doing it Yourself

Signature of person completing this history form:

_____Date: _____/_____/_____

Reviewed By:_____Date: _____/_____/_____

Name:_____ Date of Birth: _____/_____/_____

Medications List

Today's Date:_____

Please list all prescription and over the counter medications you take regularly (or attach additional sheet):

Medication	Dose	Frequency	Reason

(Note to therapists: If new medications are added during episode of care, please date and initial any additions.)