Please answer all of the following questions completely. This information is an important part of your evaluation and assists us in formulating an individualized treatment plan to meet your needs.

### Current Information

**Occupation:**

What is the main concern that brings you to therapy today?

When and how did this problem begin?

How would you rate your pain? Please mark the location(s) of your symptoms on the body chart:

- At best – 0 1 2 3 4 5 6 7 8 9 10
- At worst – 0 1 2 3 4 5 6 7 8 9 10
- 0 = no pain; 10 = worst pain imaginable

Check any boxes where you are having symptoms or difficulty:

- Walking _____ minutes
- Prolonged standing _____ minutes
- Prolonged sitting _____ minutes
- Balance
- Bathing
- Bending
- Dressing
- Driving
- Exercise
- Housework
- Lifting
- Reaching
- Recreation/Hobbies
- Sit to stand
- Sleeping
- Stairs
- Turning
- Work duties
- Other

What helps DECREASE your symptoms?

- Rest
- Ice
- Heat
- Exercise
- Changing positions
- Stretching
- Medication
- Other

What activities were you able to do before symptoms started?

Please check any equipment you are presently using:

- Bath/shower chair
- Brace
- Cane
- Commode chair
- Raised toilet seat
- Walker

Do you have steps inside or outside the home? If yes, how many? Railing? Yes No

Have you received any previous therapy or other treatment for this problem? Yes No

If yes, what type of treatment did you receive?

Did it help? Yes No

Please turn page over and continue
Health History

Do you have or have you had any health problems? (Check ALL that apply)

- Diabetes: □ Yes □ No
- Cancer: □ Yes □ No
- Heart Problems: □ Yes □ No
- High Blood Pressure: □ Yes □ No
- Osteoporosis: □ Yes □ No
- Pacemaker: □ Yes □ No
- Prednisone treatment: □ Yes □ No
- Other ___________________________

Please list any surgeries or procedures:

- Please check those that apply:
  - Bladder changes: □ Yes □ No
  - Bowel changes: □ Yes □ No
  - Difficulty breathing: □ Yes □ No
  - Dizziness/lightheadedness: □ Yes □ No
  - Double vision: □ Yes □ No
  - Fainting: □ Yes □ No
  - Thoughts of harming yourself or others: □ Yes □ No
  - Unexplained weight loss/gain of 10 lbs: □ Yes □ No
  - Fever/Chills: □ Yes □ No
  - Nausea/vomiting: □ Yes □ No
  - Night pain: □ Yes □ No
  - Numbness: □ Yes □ No
  - Sexual dysfunction: □ Yes □ No
  - Sadness/Hopelessness: □ Yes □ No
  - Recent Infections: □ Yes □ No

Have you fallen within the last 12 months? □ Yes □ No - If yes, how many times? __________

Were you injured? ___________________________

Do you have any allergies or adverse reactions (adhesive tape, latex, steroids, cleaning solutions)? □ Yes □ No

What diagnostic tests have you had relating to this current problem? Please list the dates.

- X-ray ___________________________
- MRI ___________________________
- Bone density ___________________________
- Other ___________________________

Medications

Are you taking any medication? □ Yes □ No - If yes, please list all medications you are currently taking (anticoagulants, steroids, blood pressure, etc.). If more than 4 medications, please use attached sheet.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Direction for Use</th>
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Goal(s)

What are your GOALS for therapy? ___________________________

Thank you for taking the time to provide us with this important information.
PATIENT EDUCATION ASSESSMENT

Date: _________________

In order to help us in meeting your education needs, please take the time to answer the questions below.

Person completing the form: ☐ Patient ☐ Family ☐ Significant Other ☐ Healthcare Professional

1. Is English your primary language? ☐ Yes ☐ No
   Do you have another language in which it is easier for you to communicate? Preferred language: ____________________________
   ☐ Yes ☐ No

2. Do you have any problems with your vision or hearing that might affect how we teach you? If yes, please explain:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   ☐ Yes ☐ No

3. How would you prefer to receive information regarding your care? (Check all that apply):
   ☐ Written ☐ Verbal ☐ Demonstrate ☐ Other: ____________________________

4. Do you have any beliefs or practices that might affect how we teach you? If yes, please explain (such as religious, cultural, or spiritual):
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   ☐ Yes ☐ No

5. Are you ready to receive health instruction? ☐ Yes ☐ No
   If no, please explain: __________________________________________
   __________________________________________________________
   __________________________________________________________

6. Comments: __________________________________________________
   __________________________________________________________
   __________________________________________________________
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   __________________________________________________________
Outpatient Rehabilitation | Santa Monica – 15th St.

1260 15th Street - Suite 900 | Santa Monica, CA 90404
Telephone: (310) 319-4646
www.rehab.ucla.edu

WELCOME!

Welcome to UCLA Outpatient Rehabilitation Services. We are pleased that you and your physician have chosen UCLA to meet your rehabilitation needs. Your primary therapist is ____________________, and your first appointment is _____________________.

We offer a team approach, involving the primary therapist and other skilled staff members. Your primary therapist will coordinate your care, and you may be seen by other team members for the best possible outcome.

Your involvement in this treatment process is important! Your therapist will evaluate you and design a program to address your specific problems. After evaluation, you, your therapist and your physician will determine the number of visits needed to reach your goals. The goals and number of visits needed to achieve them will be reviewed with you on a regular basis and may change from the number initially set. Regular attendance and following the exercises and recommendations of your therapist will help you achieve your goals.

PAYMENTS

You are responsible for services not covered by your insurance. Some carriers require co-payments be paid each visit. For those patients with a deductible and coinsurance, Patient Business Services will bill your insurance first and then bill you if there is a remaining balance. Patients without insurance coverage will be asked for payment at the time services are rendered.

SPLINTS/DEVICES

If you receive a splint, orthotic or prosthetic device and are having fitting problems, please contact us. Some circumstances may require a return visit to your physician.

PARKING

Self-parking is available in the ground floor of our building. Rates are posted at the entrance. Metered street parking and city lot parking is available; read posted signs carefully.

SCHEDULING

Prior to scheduling your first visit, we must have a signed physician order in the department. The therapist will determine the number of visits, the length of the visits and with whom to schedule your appointments.

If you must cancel or change an appointment, please contact us at least 24 hours prior to the scheduled time.

Cancellations within 24 hours of the appointment may result in a late cancellation fee.

If your insurance is Medicare, your physician will be required to submit a request for continued care every 30-90 calendar days. Without this new prescription from your physician, you will be discharged from therapy.

Other reasons to be discharged from therapy include the following:

- Lack of current order
- By order of your physician
- “No showing” for an appointment and not contacting us within two working days.
- By missing two scheduled appointments without valid reason
- Gap in attendance of more than 30 days
- Intervening acute medical problem or surgery
- Inability to participate in therapy
- Lack of measurable and sustainable goals
- Attaining treatment goals
- Insurance company fails to authorize additional treatments

MEDICAL RECORDS

If you would like a copy of your treatment notes, you must provide a written request. Request should be addressed to:

UCLA Medical Correspondence
10833 Le Conte Ave., Room BH-225
Los Angeles, CA 90095-1677
(310) 825-6021 Telephone
(310) 825-3356 Fax

There may be a charge for providing this record.

WE LOOK FORWARD TO WORKING WITH YOU TO HELP YOU REACH YOUR FULL POTENTIAL!