UCLA Rehab Intake Patient Assessment

Date Prepared: _____

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?

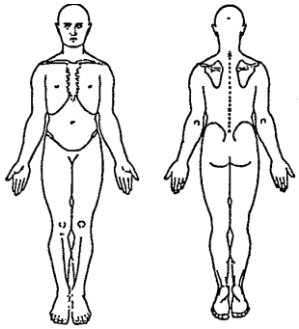
When and how did this problem begin?

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		Osteoporosis ☐ Yes ☐ No	
Cancer ☐ Yes ☐ No		Pacemaker ☐ Yes ☐ No	
Heart Problems ☐ Yes ☐ No		Prednisone treatment ☐ Yes ☐ No	
High Blood Pressure ☐ Yes ☐ No			

Other _____

Please list any surgeries or procedures:

Are you currently experiencing any of the following? Please check those that apply:

Bladder changes ☐ Yes ☐ No		Fever/Chills ☐ Yes ☐ No	
Bowel changes ☐ Yes ☐ No		Nausea/vomiting ☐ Yes ☐ No	
Difficulty breathing ☐ Yes ☐ No		Night pain ☐ Yes ☐ No	
Dizziness/lightheadedness ☐ Yes ☐ No		Numbness ☐ Yes ☐ No	
Double vision ☐ Yes ☐ No		Sexual dysfunction ☐ Yes ☐ No	
Fainting ☐ Yes ☐ No		Sadness/Hopelessness ☐ Yes ☐ No	
Thoughts of harming yourself or others ☐ Yes ☐ No		Recent Infections ☐ Yes ☐ No	
Unexplained weight los/gain of 10 lbs ☐ 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.

Medication	Dose	Direction for Use

Goal(s)

What are your GOALS for therapy? _____

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

UCLA Health System

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:** _____

_____

_____

_____

_____

_____

_____

_____

UCLA Health System

Outpatient Rehabilitation | 1000 Veteran Avenue

1000 Veteran Ave. Los Angeles, CA 90095
(310) 794-1323
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

Pay-by-Space metered self-parking is available in the Lot 32, near our building. For your convenience, valet parking is also available, and rates are posted.

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. **Cancelations 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!