REHAB SERVICES
PATIENT QUESTIONNAIRE – SUMMARY LIST

1. HIGHEST GRADE COMPLETED (CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10 11 12

   Post high school education, list: _____

2. What is your preferred language? _____

3. What is your preferred method of learning? (Check more than one if needed)

   ☐ Demonstration

   ☐ Verbal Instruction

   ☐ Written Instruction

4. Do you have any cultural or religious beliefs that could impact your care? ☐ Yes ☐ No

   If yes, please describe: _____

5. Do you require any of the following? Please check all that apply.

   ☐ Glasses ☐ Hearing Aid ☐ Interpreter

6. Employment/Work:

   ☐ Work Full Time ☐ Work Part-Time ☐ Light Duty ☐ Retired

   ☐ Unemployed ☐ Student ☐ Work From Home ☐ Work Restriction

7. How would you rate your physical condition? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

8. Check any of the following conditions that you have now, or have had in the past:

☐	Alzheimer's	☐	Depression	☐	Liver Disease
☐	Anxiety	☐	Diabetes	☐	Metal/Foreign Object Implant
☐	Anemia	☐	Dizziness/Fainting	☐	Motor Vehicle Accident
☐	Angioplasty Date: _____	☐	Drug Use/Abuse	☐	Numbness in Extremities
☐	Arthritis	☐	Emotional/Psychological Abuse	☐	Pacemaker
☐	Asthma	☐	Epilepsy/Seizures	☐	Pneumonia
☐	Bleeding Disease	☐	Fracture	☐	Shortness of Breath
☐	Blood Clot	☐	Gout	☐	Sleep Disorder
☐	Bowel/Bladder Problem	☐	Hernia	☐	Stomach Ulcer
☐	Bronchitis	☐	High Blood Pressure	☐	Stroke Date: _____
☐	Carpal Tunnel Syndrome	☐	Heart Attack Date: _____	☐	Thrombophlebitis
☐	Cancer, Type: _____	☐	Open Heart Surgery Date: _____	☐	Tuberculosis
☐	Congenital Heart Disease	☐	Hepatitis	☐	Varicose Veins
☐	COPD/Emphysema	☐	Kidney Disease	☐	Vision/Hearing Difficulties
☐	Currently Pregnant	☐	Latex Sensitive	☐	Other: _____

Have you had any thoughts of harming yourself? ☐ Yes ☐ No

9. List ANY surgeries that you have had and the date of each: _____

   _____

   _____

10. Explain if you have any other significant medical problems: _____

_____

11. Is an attorney involved in this case? ☐ Yes ☐ No

12. Have you received any therapy in the past for this diagnosis? ☐ Yes ☐ No

If yes, list type of therapy and date received: _____

_____

13. Do you understand/know what your diagnosis/injury is? ☐ Yes ☐ No

14. What are your goals for physical therapy?

☐	AVOID SUREGRY		☐	INCREASE FUNCTION
☐	REDUCE PAIN TO ___/10	ACCEPTABLE PAIN LEVEL ____/10	☐	IMPROVE FLEXIBILITY
☐	IMPROVE POSTURE		☐	PREVENT ADDITIONAL SURGERY
☐	INCREASE STRENGTH		☐	PREPARE FOR SURGERY
☐	WALK UNASSISTED		☐	INCREASE STABILITY
☐	RETURN TO FULL ACTIVITY		☐	OTHER: _____
☐	INCREASE CARDIOVASCULAR ENDURANCE			

15. What activities are not performing or having difficulty performing because of your current problem/pain?

☐	VACUUMING	☐	BATHING/DRESSING	☐	WALKING
☐	DRIVING	☐	LIFTING 1O LBS.	☐	WORK ACTIVITIES
☐	GARDENING	☐	LAUNDRY	☐	GOLF
☐	COOKING	☐	CLEANING	☐	SHOPPING
☐	MAKING THE BEDS	☐	TENNIS	☐	OTHER: _____

16. We occasionally have interns who perform clinical rotations at our facility. Do you agree to allow an Intern to perform and/or observe your treatment? ☐ Yes ☐ No

17. In the event my therapist recommends continued exercise in the Fitness Center, I hereby authorize St. Vincent's Rehab Services to release copies of my Medical Record to St. Vincent's' Fitness Center?

☐ Yes ☐ No (Not applicable for St. Clair.)

To the best of my knowledge, this confidential information is correct.

Patient Signature: _____ Date: _____ Time: _____

Therapist Signature: _____ Date: _____ Time: _____