REHABILITATION SERVICES
PATIENT QUESTIONNAIRE

PATIENT NAME: _____
MR#/ACCT#: _____
PHYSICIAN: _____
DATE: _____

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

- ❑ Some college / technical school
- ❑ College graduate
- ❑ Graduate school / advanced degree

SOCIAL HISTORY

2. With whom do you live?

❑ Alone ❑ Sitter ❑ Spouse ❑ Patient is primary caregiver
❑ With Family ❑ Other: _____

3. Employment/Work

❑ Working full-time ❑ Working part-time ❑ Retired
❑ Unemployed ❑ Student ❑ Work from home
Occupation: _____

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- ❑ House
- ❑ Assisted living
- ❑ Apartment

5. Equipment used:

- ❑ Cane
- ❑ Walker
- ❑ Wheelchair

Do you have?

- ❑ Stairs to climb
- ❑ Railing
- ❑ Uneven terrain
- ❑ Glasses, hearing aids
- ❑ Assistive devices for bathing/dressing
- ❑ Other: _____

5. GENERAL HEALTH STATUS

a) Have you had any major life changes during the past year? (e.g., new baby, job change, death of a family member, etc.) ❑ Yes ❑ No

b) Please rate your physical condition
❑ Excellent ❑ Good ❑ Fair ❑ Poor

c) Do you exercise beyond normal daily activities? ❑ Yes ❑ No
If yes, explain: _____

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6. Medical History (Please check all that apply.)

I have/have had this condition:	**Medications**
❑ Coronary heart disease	
❑ Congenital heart disease	
❑ Heart murmurs	
❑ Angina (chest pains)	
❑ Irregular heart beats	
❑ **Do you have a pacemaker?**	
❑ Valve problems	
❑ Heart attack	
❑ High blood pressure	
❑ Stroke	
❑ Diabetes	
❑ Epilepsy/Seizures	
❑ Cancer - Type:	
❑ Stomach ulcers	
❑ Lung disease (COPD, asthma, emphysema…) - Please explain:	
❑ Arthritis Type:_____Where:_____	
❑ Osteoporosis Hip Score_____ Spine Score_____	
❑ Surgery within last 12 months - When and what type:	
❑ Any chronic illness or condition - What type?	
❑ Allergies - Please list:	
❑ **Do you think you may have an infection? - Please explain:**	
❑ Hernia (or any condition which may be aggravated by lifting weights)	
❑ Do you currently smoke?	
❑ Are you a previous smoker?	
❑ **Are you pregnant/or think you might be?**	
❑ Memory Loss, Alzheimer's, Dementia	
❑ Circulation/Vascular Problems_____	
❑ Broken bones_____Location_____	
❑ Depression_____	
❑ Other – Please Explain:_____	
_____	

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7. FUNTIONAL STATUS/ACTIVITY LEVEL (Check all that apply.)

a) ❑ Difficulty with locomotion/movement:
- ❑ Bed mobility
- ❑ Transfers (such as moving from bed to chair, from bed to commode)
- ❑ Gait (walking)

❑ On level ❑ on stairs ❑ on ramps ❑ on uneven terrain

b) ❑ Difficulty with self-care (such as bathing, dressing, eating, toileting)

c) ❑ Difficulty with home management (such as household chores, shopping, gardening, driving/transportation, care of dependents)

d) ❑ Difficulty with community and work activities/integration
- ❑ Work/school
- ❑ Recreation or play activity (golf, tennis, bowling, etc.)

8. CURRENT CONDITION (S)/CHIEF COMPLAINT (S)

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

b) When did the problem/pain begin (date)? Month _____ Year _____

c) What happened? _____

d) Have you ever had the problem/pain before? ❑ Yes ❑ No
If yes, what did you do for the problem(s)? _____
_____

e) Did the problem(s) get better? ❑ Yes ❑ No
If yes, about how long did the problem/pain last? _____

f) List any test you have had for this problem/pain (X-ray, MRI, CT Scan, etc) and results if known:_____

g) Are you taking any medications for the conditions for which you are seeing the physical therapist? ❑ Yes ❑ No If yes, please list:_____
_____

h) How are you taking care of the problem/pain now? _____

i) What makes the problem/pain better? _____

j) What makes the problem/pain worse?_____

If you are being seen for treatment of your pain:

k. Please indicate the location of your pain
(Shade in the drawing)

l. Describe your pain:
___sharp
___dull
___aching
___shooting
___throbbing
___other_____

Is your pain:
___constant
___intermittent
___variable

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You will be asked to rate your pain. A numeric scale is used (see below). A rating of 0 means you have no pain, while a rating of 10 means your pain is unbearable and of such intensity you must go to the emergency room, immediately. Please rate your pain as it is presently (#9), and what the maximum level of pain you have experienced in the last few days (#10).

9. PLEASE RATE THE INTENSITY OF YOUR <u>PRESENT</u> PAIN (CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

NO PAIN MODERATE PAIN INTENSE PAIN(REQUIRES IMMEDIATE ER VISIT)

10. PLEASE RATE THE INTENSITY OF YOUR PAIN WHEN IT IS AT ITS <u>WORST</u> (CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

NO PAIN MODERATE PAIN INTENSE PAIN(REQUIRES IMMEDIATE ER VISIT)

If you have a diagnosis involving pain, your therapist will discuss the role treatment of pain will have in your rehabilitation. Adequate relief of your pain may allow you to achieve goals set for improving your ability to perform daily activities.

You will be asked by your therapist to rate your pain at each treatment session. This will give us information to determine if we are achieving your goals in relation to pain reduction.

Additionally, your therapist will discuss with you self management techniques to control your pain.

If your pain is not being adequately controlled, please discuss this with your therapist.

11. What are your goals for physical therapy?

- ❑ REDUCE PAIN TO __/10
- ❑ INCREASE FUNCTION
- ❑ IMPROVE POSTURE
- ❑ IMPROVE FLEXIBILITY
- ❑ INCREASE STRENGTH
- ❑ PREVENT ADDITIONAL SURGERY
- ❑ WALK UNASSISTED
- ❑ PREPARE FOR SURGERY
- ❑ RETURN TO FULL ACTIVITY
- ❑ INCREASE STABILITY
- ❑ INCREASE CARDIOVASCULAR ENDURANCE
- ❑ OTHER_____

12. What activities are you not performing because of your current problem/pain?

❑ VACUUMING	❑ MAKING THE BEDS	❑ LAUNDRY	❑ GOLF
❑ DRIVING	❑ BATHING/DRESSING	❑ CLEANING	❑ DANCING
❑ GARDENING	❑ PLAYING CARDS	❑ TENNIS	❑ SHOPPING
❑ COOKING	❑ LIFTING 10 LBS.	❑ OTHER	

13. We occasionally have interns who perform clinical rotations at our facility. Do you agree to allow an intern to perform your treatment? ❑ Yes ❑ No

14. 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

I hereby acknowledge receipt of the pamphlet regarding appointment scheduling at the Bruno Rehab Center.

Patient's Signature:_____ Date:_____

Therapist's Signature:_____ Date:_____