Advanced Neurologic Rehabilitation

PATIENT QUESTIONNAIRE

Patient Name:_____ Height:_____Weight:_____Date of Birth: _____

Reason for Visit_____

Diagnosis _____ Onset Date _____

Medical History:

- ❑ Stroke/TIA
- ❑ Brain injury/concussion
- ❑ Parkinson's disease
- ❑ Multiple Sclerosis
- ❑ Spinal cord injury
- ❑ Neuropathy/Sensory loss
- ❑ Siezure disorder
- ❑ Dementia/Alzheimer's
- ❑ Heart attack/CAD/CHF
- ❑ High/Low blood pressure
- ❑ Cardiac Surgery/Pacer
- ❑ Aryhthmia/Afib
- ❑ Smoking
- ❑ Asthma, COPD, Emphysema
- ❑ Cancer history
- ❑ Weight loss
- ❑ Anxiety/Depression
- ❑ Psychological
- ❑ Thyroid disease
- ❑ Neck injury/surgery
- ❑ Back injury/surgery
- ❑ Hip injury/surgery
- ❑ Knee injury/surgery
- ❑ Vertigo/Dizziness
- ❑ Diabetes
- ❑ Anemia
- ❑ Ulcer/Wound
- ❑ Hernia/Surgery
- ❑ Osteoporsis
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Gout

Complaints:

- ❑ Weakness
- ❑ Pain
- ❑ Sensation loss
- ❑ Balance & Disequilibrium
- ❑ Gross & Fine Motor Control
- ❑ Dizziness/Vertigo
- ❑ Expressive/Receptive language
- ❑ Articulation/Fluency
- ❑ Swallowing
- ❑ Memory & Attention
- ❑ Hearing loss/ Tinitus
- ❑ Migraine & Headache

I need help for the following activities:

- ❑ Getting into/out of bed
- ❑ Getting into/out of the car
- ❑ Standing up from a chair
- ❑ Walking
- ❑ Bathing/Showering
- ❑ Getting dressed
- ❑ Meal preparation
- ❑ Eating/Using utensils
- ❑ Driving
- ❑ Medications
- ❑ MD appointment

I own the following Assistive Device(s) & Medical Equipment:

- ❑ Walker
- ❑ Cane
- ❑ Splint/Brace
- ❑ Manual wheelchair
- ❑ Powerchair/Scooter
- ❑ Orthotic/Prosthetic
- ❑ Shower chair/tub bench
- ❑ Hospital bed
- ❑ Communication device
- ❑ Grab bars
- ❑ Other: _____

Living Situation:

Residence: ❑ apartment ❑ 1-story house ❑ 2-story house ❑ Assisted Living ❑ other: _____

With: ❑ family/other caregiver ❑ alone ❑ other: _____

Pets? ❑ yes ❑ no

Occupation: _____ ❑ retired ❑ full-time ❑ part-time

Pain:

Do you have pain? ❑ Yes ❑ No *(If no, skip to next section)*

Please describe your pain: _____

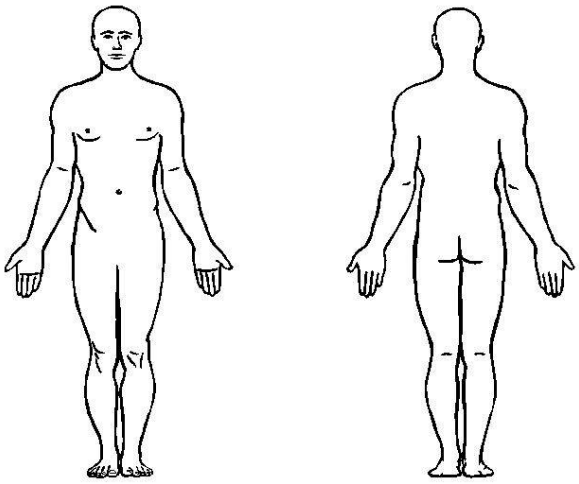
Rate your pain: *("0" = no pain, "10 = worst pain possible)*

Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

Things that relieve your pain: _____

Things that make your pain worse: _____

Current treatment: _____



Please mark the location of your pain

Medications:

Name:	Dosage:	Name:	Dosage:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WHAT ARE YOUR GOALS FOR THERAPY?

Walking and balance goals: _____

Arm and Hand goals: _____

Speech and Swallowing goals: _____

Other: _____

This form was completed by ❑ Patient ❑ Friend ❑ Parent ❑ Other ❑ Staff _____ (initials)

I hereby acknowledge that the completed information is accurate.

X_____Date: _____/_____/_____