

**Palos Community Hospital
Physical Medicine & Rehabilitation
OUTPATIENT QUESTIONNAIRE**

Date: _____

Thank you for taking the time to fill out this questionnaire. It will assist your doctor/therapist in planning safe and effective treatment. Please check the information that has an asterisk (*) for accuracy and completeness.

* Name: _____ Age: _____ Sex Male Female

Height: _____ Weight: _____ Occupation: _____ Right handed Left handed

Home Environment/Safety Barriers: Live alone Live with family Assisted living
 House Apartment/condo Stairs
 Caregiver: 24 hours Part time

Do you expect the above living arrangements to change as a result of treatment? _____

What problems do you have that you are seeking treatment for? How long have you had this problem?

WHAT PROBLEM?

LENGTH OF TIME?

* _____

* Have you ever had treatments for any of these problems in the past?

TYPE OF TREATMENT

WHERE

DATES

Are you receiving Home Health Services (nursing, therapy, injections)? Yes No If yes, describe: _____

Have you received any Home Health services (nursing, therapy, injections) in the past 30 days? Yes No

Indicate if you are seeing any other providers or receiving other services for this condition: *(For example, physician, chiropractor, nurse, social services, dietitian, nutritionist, radiation, chemotherapy, psychologist, physical, occupational, speech or respiratory therapist)* _____

What results do you expect from treatment?

Please check any tests/procedures that you have had for these problems. Please list results and facility.

	Results	Facility		Results	Facility
<input type="checkbox"/> X-rays	_____	_____	<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> CT scan	_____	_____	<input type="checkbox"/> Myelogram	_____	_____
<input type="checkbox"/> MRI	_____	_____	<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Bone scan	_____	_____	<input type="checkbox"/> Other _____	_____	_____

Check any of the following medical problems you have ever had:

- Arthritis
- Osteoarthritis
- Rheumatoid Arthritis
- Seizures
- Thyroid problems
- Nerve damage
- Bowel/bladder incontinence
- Dizziness/blackouts
- Cancer
- Lung disease
- Kidney disease
- Heart disease
- Diabetes
- High blood pressure
- Stomach ulcers
- Gout
- Vision problems
- Hearing problems
- Stroke
- Osteoporosis
- None of the above medical problems

Allergies: To iodine To bees To tape To latex Other _____

Drug allergies to: _____

Other medical problems we should know about? _____

Do you take medications or drugs (including nonprescription drugs)? Yes No If yes, describe below:

NAME OF MEDICATION / DRUGS

FOR WHAT?

Please list any equipment you are using for this condition (*for example, walker, crutches, cane, traction unit, stimulation unit, etc.*) _____

Do you drink alcoholic beverages? Yes No If yes, how much? _____

Do you smoke? Yes No If yes, how much? _____

Do you have any metal implants? Yes No

Do you have any tendency for bleeding? Yes No

Do you have a cardiac pacemaker? Yes No

Women Only:

Do you think you might be pregnant? Yes No

Do you have your menses at this time? Yes No

Referring physician: _____

When is your next appointment with this doctor? _____

Other doctors involved with case: _____

Rehabilitation specialist or nurse and phone number: _____

Are you currently working? Yes No

If no, what was the last day worked? _____

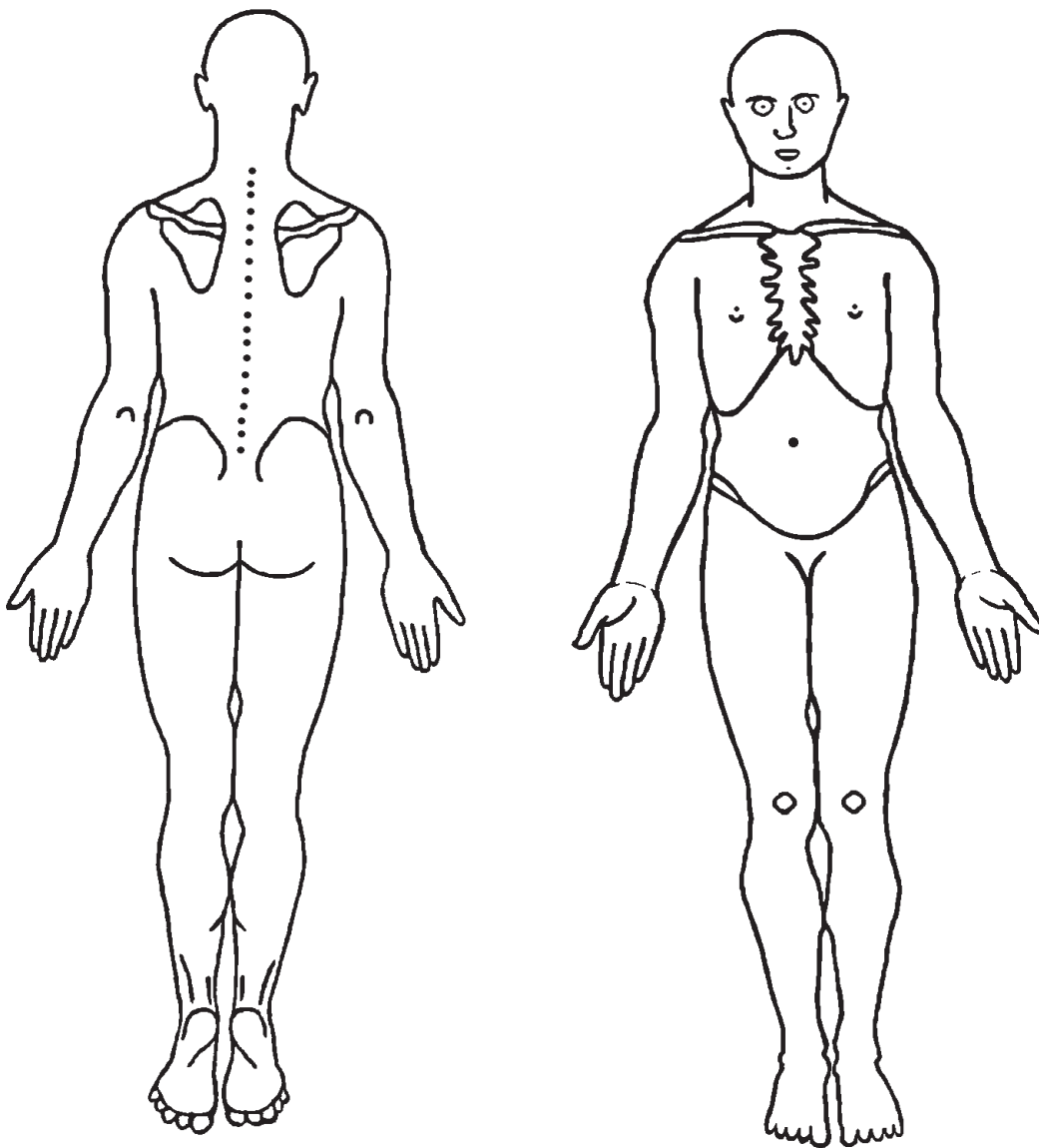
If yes: 1. Are you working Full duty Light duty – Restrictions _____

2. Have you missed any days due to this injury? Yes No

If yes, How many? _____ When did you return to work? _____

Mark the areas of the body where you feel the described sensations. Use the appropriate symbol.

	===		EEEE		xxxx		/////		*****
Numbness	===	Pins & Needles	EEEE	Burning	xxxx	Sharp or Stabbing	/////	Dull	*****
	===		EEEE		xxxx		/////		*****



PAIN RATING

Please circle the description of your pain:

At best:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain		Discomforting		Distressing		Horrible		Emergency

At worst:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain		Discomforting		Distressing		Horrible		Emergency