REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Please answer all questions to the best of your knowledge

Do you have any known allergies (drugs, food, pollens, latex etc): _____

Have you had any falls in the last 12 months (please circle)? **Yes** **No**

How many falls? _____ Did any fall result in injury? **Yes** **No**

Have you had any near falls? **Yes** **No** How many in the last 12 months? _____

How do you learn best (please circle): **Reading** **Demonstration** **Pictures** **Listening**

Do you feel safe in your home (please circle)? **Yes** **No**

Are you being threatened or hurt by someone (please circle)? **Yes** **No**

Over the past 2 weeks, how often have you been bothered by any of the following problems (please circle)?

	Not At All	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
Little Interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

What is your preferred language? _____

Which language do you want to use while you are receiving services here? _____

Do you have, or have you had, any of the following?

- ☐ Aids/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma, Bronchitis, COPD, or Emphysema
- ☐ Cancer
- ☐ Cardiac History (Angina, Congenital Heart Disorder, Heart Attack, Pace Maker, Defibrillator, Palpitations, Irregular Heartbeat, Other)
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness or Vertigo
- ☐ Edema
- ☐ Emotional/Psychological Problems
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Frequent Cough
- ☐ Gout
- ☐ Headaches or Migraines
- ☐ Hearing Difficulties or Ringing in your ears
- ☐ Hepatitis A, B or C
- ☐ High/Low Blood pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Memory Loss or Cognitive Problems
- ☐ Nausea/Vomiting
- ☐ Orthopedic History
- ☐ Osteoporosis
- ☐ Pain
- ☐ Pregnant or Nursing
- ☐ Recent Weight loss
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Abnormalities
- ☐ Sleeping Difficulties
- ☐ Speech Problems
- ☐ Swallowing Problems
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Surgery
- ☐ Thyroid Disease
- ☐ Traumatic Brain Injury
- ☐ Vision Problems (Galucoma, Cataracts, Macular Degeneration, etc)
- ☐ Other _____ _____ _____

Comments and details regarding above history (surgeries and medication on next page): _____

_____

Has the patient OR a sick close contact had international travel with in the last 30 days? **Yes** **No**

Where was the travel to and on what dates? _____

Does the patient currently have a fever OR flu-like symptoms? **Yes** **No**

(Symptoms include headache, aches, vomiting, abdominal pain, diarrhea, chills, etc)

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Major Surgeries	Date	Current Medication	Dosage	Frequency

(Please ask for surgery/medication form if more space is needed)

Therapist Review – Office Use only

Have you previously participated in physical/occupational/speech therapy? **Yes** **No**

Have you had therapy services this calendar year? **Yes** **No**

Were you treated for your current diagnosis or another diagnosis? **Current** **Different**

Have you had any recent imaging performed (please circle)?

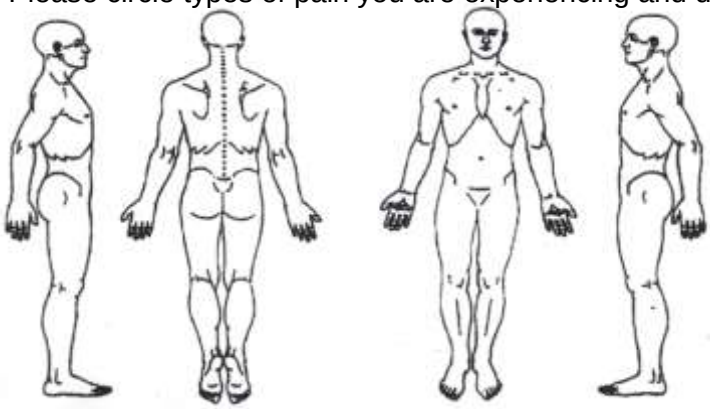
X-ray **CT scan** **MRI** **EMG** **Modified Barium Swallow** **Other**

Do you have any restrictions from activity from your doctor? **Yes** **No**

If yes, please explain: _____

What are your goals for therapy? _____

Please circle types of pain you are experiencing and draw or shade in areas of pain on the diagram:



Aching	**Burning**	**Cramping**
Dull	**Numbness**	**Pins & Needles**
Radiating	**Sharp**	**Shock Like**
Spasm	**Squeezing**	**Stabbing**
Throbbing	**Tightness**	**Tingling**
Tiring	**Other: Please explain**	_____

Advanced Directives: ☐ Durable Power of Attorney ☐ Living Will ☐ Organ Donor ☐ DNR ☐ N/A

Patients Name (Please write legibly): _____

Signature of Patient: _____ Date:_____

Signature of Caregiver (if under 18 or assisting in filling out form): _____

Signature of Therapist: _____ Date:_____

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RS-027 (0816)

REHABILITATION SERVICES – OUTPATIENT MEDICAL QUESTIONNAIRE

PATIENT LABEL