Rehabilitation Medicine Clinic
New Patient Questionnaire

(Please complete this 5-page form and bring to your appointment.)

Date__________________**Appt. Date**___________ **Age**___________ **Date of Birth**_____________

Name______________________________________ ☐ **Male** ☐ **Female** **Hand dominance:** ☐ R ☐ L

Home Address______________________________ **Home Phone (** **)**________________________

____ **Work Phone (** **)**________________________

City **State** **Zip** **Other Phone (** **)**________________________

Marital Status: ☐ Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced ☐ Common Law

Occupation______________________________________

If unemployed, how long?__________ ☐ Mos ☐ Yrs

Education____

Medical Insurance Company: ____

Reason for clinic visit? List the 4 most important things that you would like us to help you with during your visit. This might include questions, concerns, or symptoms that need treatment.

1.____
2.____
3.____
4.____

Referring Doctor________________________________
Address____
____
Phone (**)**___________________________________
Fax (**)**_____________________________________

Primary Care Doctor____________________________
Address____
____
Phone (**)**___________________________________
Fax (**)**_____________________________________

Please list any other health care providers you have:

Name & Specialty________________________________
Phone (**)**_______________**Fax (** **)**______________
Name & Specialty________________________________
Phone (**)**_______________**Fax (** **)**______________

Name & Specialty________________________________
Phone (**)**_______________**Fax (** **)**______________
Name & Specialty________________________________
Phone (**)**_______________**Fax (** **)**______________

Does your visit involve a legal case? ☐ **Yes** ☐ **No**
Lawyer's Name__________________________________
Phone (**)**_______________**Fax (** **)**______________
Address ____

Allergies (medications & others):
____

List medical problems and surgeries (list year):

____
____
____
____
____
____
____
____
____

Current Medications:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

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MD initials and date:

Review of Symptoms: Please mark (x) in the box if any of the following apply to you personally:

Yes Now	Yes Past	No	Neurologic/Psychiatric
☐	☐	☐	Weakness
☐	☐	☐	Change in sweating pattern
☐	☐	☐	Difficulty walking
☐	☐	☐	Fainting spells (blackouts)
☐	☐	☐	Lack of energy (fatigue)
☐	☐	☐	Loss of balance
☐	☐	☐	Loss of feeling in part of body
☐	☐	☐	Headaches
☐	☐	☐	Tremor (shaking, trembling)
☐	☐	☐	Trouble sleeping
☐	☐	☐	Anxiety
☐	☐	☐	Depression (feeling sad)
☐	☐	☐	Crying spells
☐	☐	☐	Excessive worry
☐	☐	☐	Memory trouble
☐	☐	☐	Trouble concentrating
			Eyes
☐	☐	☐	Blurry vision even with glasses
☐	☐	☐	Double vision (diplopia)
☐	☐	☐	Loss of vision in one eye
			Ears, nose, Mouth, Throat
☐	☐	☐	Dizziness
☐	☐	☐	Ear pain
☐	☐	☐	Hearing trouble
☐	☐	☐	Ringing in the ears (tinnitus)
☐	☐	☐	Trouble breathing through nose
☐	☐	☐	Sore mouth
☐	☐	☐	Teeth trouble
☐	☐	☐	Persistent hoarseness
☐	☐	☐	Voice change
☐	☐	☐	Swallowing trouble
			Heart
☐	☐	☐	Chest pain
☐	☐	☐	Strong heart beat (palpitations)
☐	☐	☐	Leg pain when walking
☐	☐	☐	Ankle swelling

Yes Now	Yes Past	No	Genitourinary
☐	☐	☐	Frequent urination
☐	☐	☐	Painful urination
☐	☐	☐	Trouble starting urine
☐	☐	☐	Trouble holding urine
☐	☐	☐	Urinate more than twice per night
☐	☐	☐	Blood in urine
☐	☐	☐	Sexual problems
☐	☐	☐	**(Males)** Erection difficulty
☐	☐	☐	**(Males)** Discharge from penis
☐	☐	☐	**(Males)** Problems with testicles
☐	☐	☐	**(Females)** Unusual vaginal bleeding/discharge
☐	☐	☐	**Bones/Joints**
☐	☐	☐	Joint pain
☐	☐	☐	Joint swelling
☐	☐	☐	Chronic low back pain
☐	☐	☐	Chronic neck pain
			Breasts
☐	☐	☐	Lumps or discharge
			Constitutional/Endocrine
☐	☐	☐	Unexplained weight loss or gain
☐	☐	☐	Intolerance of heat
☐	☐	☐	Intolerance of cold
☐	☐	☐	Night sweats
☐	☐	☐	Unexplained fever
			Allergy/Immunology
☐	☐	☐	Seasonal allergies (hay fever)
☐	☐	☐	Other infections_________________________
			Lymphatic/Hematologic
☐	☐	☐	Enlarged glands (neck, groin, under arms)
☐	☐	☐	Easy bruising or bleeding
			Stomach
☐	☐	☐	Frequent nausea and/or vomiting
☐	☐	☐	Vomiting blood
☐	☐	☐	Frequent stomach pain

			Lungs
☐	☐	☐	Daily cough
☐	☐	☐	Shortness of breath
☐	☐	☐	Coughing up blood

☐	☐	☐	Chronic constipation
☐	☐	☐	Chronic diarrhea
☐	☐	☐	Bowel habit change
☐	☐	☐	Blood in stool

Family Medical History (use extra page if needed)

Family Member	Year Of Birth	If living, list major medical problems	If not living, list age and cause of death
Mother			
Father			
Children			
Brothers Sisters			

Your Health Habits

Smoker: ☐ never ☐ current ☐ past # of years ____

Amount per day________Year last quit ________

Alcohol: ☐ never ☐ current ☐ past # of years ____

Amount per week________Year last quit ________

Other drug use (describe) ______________________

Hours of sleep per night ______________________

Number of meals per day ______________________

1. **Do you have any values or beliefs we should consider when planning your care?** ☐ Yes ☐ No
   If yes, please explain:____

2. **Who do you live with?** (Check all that apply)
   ☐ I live alone ☐ Spouse / Partner ☐ Children ☐ Parents ☐ Currently homeless ☐ Other_____________

   I live in a(n): (Check/circle all that apply)
   ☐ Condo or Apartment — Which floor/# of floors:____ — Is there an elevator? Y N — # of stairs to enter: ___
   ☐ House — Number of floors:_________ — Split level? Y N — # of stairs to enter: ___
   ☐ Assisted Living Facility ☐ Nursing Home ☐ Adult Family Home ☐ Retirement Center

   Are there railings? Y N On the: R L Both sides

   Shower/bath located on: Main level Upstairs level Basement

3. **Do you need help with transportation?** ☐ No ☐ Yes If yes, check all that apply:
   ☐ Family/Friends
   ☐ Escort
   ☐ Private Patient Transportation services (cabulance)
   ☐ Other___________________________________

4. **Do you feel safe in your current living situation?** ☐Yes ☐No If no, please explain

5. **Are you currently experiencing any pain?** ☐ Yes ☐ No
   If yes, list the area and complete the scale below.
   Area of pain ____

Please rate your pain on a scale of 0 to 10. **Zero = no pain 10 = worst pain you have ever had.**

No pain									**Worst pain**	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

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What do you do to relieve your pain? ____

6. **Have you fallen in the past year?** ☐ Yes ☐ No
   - **If yes, why did you fall?** ____
   - **Were you injured?** ☐ Yes ☐ No
   - **Are you concerned that you could fall again?** ☐ Yes ☐ No

7. **Please describe your current functional abilities with the following:**

Level of assistance needed:	No help needed	1-25% assistance	26-50% assistance	51-75% assistance	76-99% assistance	100% assistance
Moving around in bed	☐	☐	☐	☐	☐	☐
Getting from laying down to sitting	☐	☐	☐	☐	☐	☐
Getting from sitting to standing	☐	☐	☐	☐	☐	☐
Walking indoors	☐	☐	☐	☐	☐	☐
Walking outdoors	☐	☐	☐	☐	☐	☐
Going up and down stairs	☐	☐	☐	☐	☐	☐
Using a wheelchair ☐ N/A	☐	☐	☐	☐	☐	☐
Putting on your shirt	☐	☐	☐	☐	☐	☐
Putting on your pants	☐	☐	☐	☐	☐	☐
Putting on your shoes/socks/ankle brace	☐	☐	☐	☐	☐	☐
Grooming (brush teeth/hair, shave, etc)	☐	☐	☐	☐	☐	☐
Showering/Bathing	☐	☐	☐	☐	☐	☐
Using the toilet or commode	☐	☐	☐	☐	☐	☐

When performing the above activities does someone need to be standing by you for safety or balance? ☐ Yes ☐ No

8. **Adaptive Equipment** (such as cane, walker, wheelchair, commode, shower bench/chair, reacher, adapted utensils, AFO, etc).
   Please list items you currently use: ____
   ____

9. Instrumental Activities of Daily Living Because of a health or physical problem, do you have any difficulty with:

Activity	Yes	No
Using a telephone?	☐	☐
Doing light housework (like washing dishes, straightening up, dusting)?	☐	☐
Doing heavy housework (like scrubbing floors, washing windows)?	☐	☐
Preparing your own meals?	☐	☐
Shopping for personal items (like groceries, medicines, toiletries)?	☐	☐
Managing money (like keeping track of money, paying bills)?	☐	☐

10. **Do you have trouble swallowing?** ☐ No ☐ Yes If yes, please circle: Solids Liquids Both
    Do you currently have any restrictions with what you can eat or drink? ☐ No ☐ Yes If yes, please describe:

11. **Are you currently driving?** ☐ Yes ☐ No
    Have there been any concerns raised by family members about your driving safety? ☐ Yes ☐ No

12. **Are you having a difficult time dealing emotionally with your current level of function?** ☐ Yes ☐ No

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13. Are you currently receiving any of these services? (circle all that apply)

Home Health	Outpatient Therapies	Rehab Without Walls	Psychology
Physical Therapy	Occupational therapy	Speech Therapy	Recreational Therapy
Visiting Nurse	Bath Aide	Paid Caregivers	Vocational counseling
Massage Therapy	Chiropractic Services	Acupuncture	Case Management/Social Work

Signature (Patient or Person Authorized to Sign) **Print Name** **Date**

If signed by person other than patient, please define your relationship to patient:

☐ Guardian ☐ Health Care Power of Attorney ☐ Parent
☐ Spouse/Registered Domestic Partner ☐ Adult child ☐ Other ___________________________

I have reviewed this information.

Physician Signature	Print Name	Date

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 Approved:

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