

Swedish Outpatient Rehabilitation Patient Intake Questionnaire

Pa	tient name	e:									
Ge	ender pron	ouns: 🗆 S	he/Her [∃He/Him □	∃They/Ther	m 🗆 Other	·				
W	hat is the c	current pr	oblem or i	njury that bri	ings you to	therapy? _					
Da	ite the prol	blem or ir	ijury bega	n:							
De	escribe you	ır sympto	ms:								
Ci				cate your pai	, -						
	0 Non	1	2	3 Minimal	4 5	6 Mar	7 derate	8 9	10 Severe		
Do			0 147axat		Ciroloo			t Interneittent			Direct
	-							t Intermittent	Acne	Sharp	bum
Pa	in or symp	otoms eas	ea by:						\bigcirc		\bigcirc
								- 6			
Pa	in or symp	otoms wo	rsened by	:				- <i>[/</i> /			
								\ \	1 / hur		Tun \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Nι	ımber of h	ours of sl	eep in 24 l	nours:				_ ((1)		(() ()
				Маг	rk location of	symptoms of	n diagram	→ FRONT	XS		васк 🐰
De	escribe you	ır daily ac	tivity leve	l/exercise rou	utine:						
(ca	annot perfo	orm), 10 =	able to pe		y at the sam	e level as b	efore injur	lle below. 0 = ur ry or problem (n r)		-	activity
1	Activity:										
1.	0	1	2	3	4	5	6	7	8	9	10
	Cannot p	erform									No issues
2.	Activity:										
	0	1	2	3	4	5	6	7	8	9	10
	Cannot p	erform									No issues
3.	Activity:										
	0	1	2	3	4	5	6	7	8	9	10
	Cannot p	erform									No issues
Do	you feel s	afe in you	ır current	relationship a	at home?			□yes □no			
Is	anyone in	your life r	misusing y	our money o	r property?			□yes □no			
Ha	ive you be	en hit, sla	pped, phy	sically hurt o	r threatened	d by your pa	rtner?	□yes □no			
W	hat is vour	nreferred	l learning	style?				70	0.000		
What is your preferred learning style? ☐ Listening ☐ Reading ☐ Observation ☐ Performance of task							FOR OFFICE USE ONLY LABEL HERE OR MRN:				
_			J - 2.30					LABEI	. HEF	KE OR	MRN:
Tu	rn over and	complete	back side								

Fill out if the information is not already in EPIC (our electronic medical record) or if provider is not a Swedish provider.

Please check the health conditions that apply to you now or in the past, briefly explain and provide dates:

	Yes	Explain		Yes	Explain
Alcohol/Drug abuse			Heart disease		*
Anemia			Hepatitis		
Arthritis			HIV/AIDS		
Asthma			Kidney/Liver		
Bleeding			Memory/Cognition		
Blood clots			Mental health		
Blood pressure			Nervous system		
Bowel or bladder			Osteoporosis		
Broken bones			Pregnant		
Cancer			Pacemaker		
Depression			Seizures		
Diabetes			Skin reactions		
Dizziness/Balance			Sleep/Snoring		
Emphysema			Stomach/Digestion		
Endocrine/Thyroid			Stroke		
Eye disease			Swelling		
Gout			Tobacco use		
Head injury			Tuberculosis		
Hearing			Weight issue		
Heartburn/Ulcer			Other:		

Current prescription, over-the-counter or herbal medications:
Adverse or allergic reactions to products (i.e., latex, tape, etc.) or drugs:
Prior injuries, major illness, surgical history and dates:
Patient signature:
Date and time:
Therapist signature:
Date and time:

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY:711)

注意:如果您講中文,我們可以給您提供免費中 文翻譯服務,請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY:711)

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LABEL HERE OR

PATIENT NAME AND MRN: