SWEDISH

Swedish Outpatient Rehabilitation Patient Intake Questionnaire

Patient Name: _____ Height: _____ Weight: _____

What is the current problem or injury that brings you to therapy? _____

_____

Date the problem or injury began: _____

Describe your symptoms: _____

Circle the number below to indicate your pain or symptoms level now:

0	1	2	3	4	5	6	7	8	9	10
None			Minimal			Moderate				Severe

Pain Range: Best __/10 Worst __/10 Circle all that apply: Constant Intermittent Ache Sharp Burn

Pain or symptoms eased by: _____

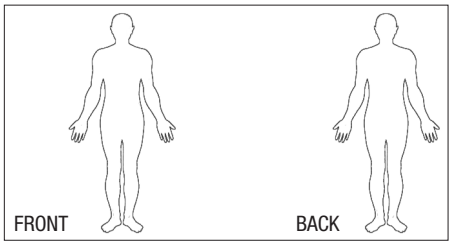
_____

Pain or symptoms worsened by: _____

_____

Number of hours of sleep in 24 hours: _____

Mark location of symptoms on diagram ➔



Describe your daily activity level/exercise routine: _____

_____

What is your occupation? _____

Current prescription, over-the-counter or herbal medications: _____

_____

_____

Adverse or allergic reactions to products (i.e., latex, tape, etc.) or drugs: _____

_____

Prior injuries, major illnesses, surgical history and dates: _____

_____

_____

Goals: What would you like to achieve with therapy treatment at Swedish? _____

_____

_____

List two activities that you have difficulty with due to the injury or problem you are here for:

1. _____ 2. _____

During the past week, how much has your injury or problem limited your normal social activities with family, friends or groups?

☐ Not limited ☐ Slightly limited ☐ Moderately limited ☐ Very limited ☐ Unable

During the past week, how much were you limited in your work or other regular daily activities as a result of the injury or problem?

☐ Not limited ☐ Slightly limited ☐ Moderately limited ☐ Very limited ☐ Unable

During the past week, how limited has your sleep been because of the injury or problem?

☐ Not limited ☐ Slightly limited ☐ Moderately limited ☐ Very limited ☐ Unable

Therapist Signature: _____

Date and Time: _____

Turn over and complete back side.

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LABEL HERE OR MRN:

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:		

At the present time would you say that your health is: ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

Comfort and Safety

Do you feel threatened, controlled, abused, or afraid in a relationship with anyone? ☐ Yes ☐ No

Are there cultural or religious beliefs that would affect your treatment plan? ☐ Yes ☐ No

Is there anything else that would impact your treatment and ability to learn? ☐ Yes ☐ No

Explain: _____

1a Have you fallen in the past year **and** are you 65 or older?
If yes, how many times? _____ ☐ Yes ☐ No

1b Do you have trouble with your balance or your walking? ☐ Yes ☐ No

2a Do you have any loss of vision? ☐ Yes ☐ No

2b Are you taking four or more medications or any mood altering medications? ☐ Yes ☐ No

2c Do you have any problems with your balance or your walking? ☐ Yes ☐ No

2d Do you have any problems with your feet? ☐ Yes ☐ No

2e Do you have anything you might trip on at home? ☐ Yes ☐ No

2f Do you become dizzy when getting up? ☐ Yes ☐ No

x Do you experience incontinence? ☐ Yes ☐ No

x Do you have any hearing problems? ☐ Yes ☐ No

Patient Signature:_____

Date and Time: _____

Therapist Use Only - Fall Risk Score	
1	1y MR* 2y HR
2	2y LR 3y MR* 4+ HR *2 MR = HR

Therapist Signature:_____

Date and Time: _____

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LABEL HERE OR
PATIENT NAME AND MRN:

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