Northwestern Medicine®

Rehabilitation Services Outpatient Questionnaire

Thank you for filling out this questionnaire. It will help your physician or therapist plan your treatment.

Name: ______________________ **Date of birth:** ____/____/____ **Date:** ____________

What is your preferred language? ☐ English ☐ Other: ____________

Height: ______ **Weight:** ______ **Age:** ______ **Sex:** ☐ Male ☐ Female **Handedness:** ☐ Right ☐ Left

Referring physician: ______________________ **Next appointment date with physician:** ____________

How did you hear about our services?

☐ Physician ☐ Website ☐ Family/friend ☐ Newspaper/ad ☐ Fitness center ☐ Social media

☐ Employee (self or referral) ☐ Other Northwestern Medicine program/care

☐ Community program (specify) ______________________ ☐ Other: ____________

Have you received any home health services in the past 30 days? ☐ Yes ☐ No If yes, explain: ____________

How often is it hard for you to understand health information? ☐ Always ☐ Often ☐ Sometimes ☐ Occasionally ☐ Never

Current condition

Describe the issue that brings you here today: ______________________

Date of surgery/onset of issue: ______________________

Are you here due to a motor vehicle accident? ☐ Yes ☐ No

Has your physician put you on any restrictions for your current injury? ______________________

Are your symptoms: ☐ Improving ☐ Staying the same ☐ Getting worse

Do any of these activities make your pain and/or your condition worse:

☐ Bending ☐ Lifting ☐ Rising from sitting ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Coughing/sneezing

☐ Turning neck/back ☐ Reaching ☐ Holding/gripping ☐ Other ____________

Do any of these activities make your pain and/or your condition better:

☐ Lying down ☐ Sitting ☐ Turning neck/back ☐ Standing ☐ Walking ☐ Bending ☐ Using heat

☐ Using a cold pack ☐ Rest ☐ Splinting ☐ Taking medication ☐ Other ____________

Have you had any testing? ☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG/nerve conduction ☐ Other ____________

Results: ______________________

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No Treatment: ____________

What is your goal for treatment? ______________________

If you have pain, what is your pain level? (0 = No pain, 10 = Extreme pain)

At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
Currently:	0	1	2	3	4	5	6	7	8	9	10

Symptom description: ☐ Numbness ☐ Pins and needles

☐ Burning ☐ Sharp ☐ Dull ☐ Constant ☐ Come and go

☐ Other ______________________

Is pain worse at a certain time of day? ☐ Yes ☐ No

☐ Morning ☐ Night ☐ Other ____________

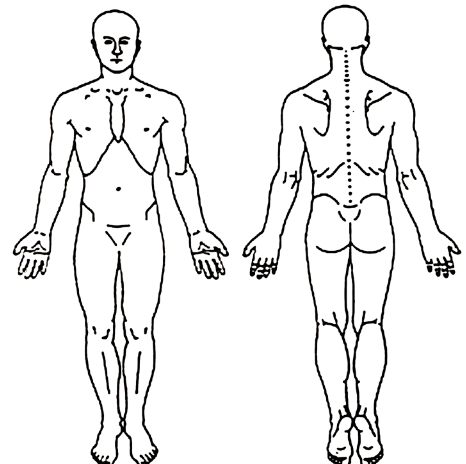
Does your pain get worse as the day goes along? ☐ Yes ☐ No

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you wake up at night due to the pain? ☐ Yes ☐ No

Number of times per night ________

Mark the location of your pain with an "X"



Current condition

Mark any activities you are unable to perform at the same level as before your current injury/condition:

☐ Squatting ☐ Sitting ☐ Driving ☐ Holding/carrying objects ☐ Working tasks ☐ Gripping/pinching
☐ Reaching ☐ Standing ☐ Walking ☐ Dressing/grooming ☐ Climbing stairs ☐ Changing positions
☐ Kneeling ☐ Lifting ☐ Doing yardwork ☐ Grocery shopping ☐ Cooking ☐ Cleaning
☐ Vacuuming ☐ Doing laundry ☐ Other ______

Did you need an assistive device (walker, cane, wheelchair) before your current injury/condition? ☐ Yes ☐ No

Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? ______ If yes, were you injured? ☐ Yes ☐ No

Do you feel unsteady when standing or walking? ☐ Yes ☐ No Do you worry about falling? ☐ Yes ☐ No

What do you do for physical activity?

______

Name 3 activities you wish to perform better by the end of therapy:

#1 ______ #2 ______ #3 ______

Work/ living environment

Living arrangements: ☐ Live alone ☐ Live with family ☐ Other: ______
☐ House ☐ Apartment/condo ☐ Stairs # of stairs ______ ☐ Caregiver: ☐ 24 hours ☐ Part-time

Occupation: ______ **Presently working?** ☐ Yes ☐ No If no, last day worked? ______

If working, ☐ Full duty ☐ Limited duty: Restrictions ______ # Days off work: ______

Job duties: ☐ Sitting ☐ Computer work ☐ Bending ☐ Twisting ☐ Heavy lifting ☐ Traveling
☐ Standing ☐ Reaching ☐ Gripping/pinching ☐ Walking ☐ Push/pulling ☐ Crawling ☐ Driving
☐ Other: ______

Check if you have ever had:

☐ Arthritis ☐ Rheumatoid arthritis ☐ Seizures ☐ Thyroid problems ☐ Anxiety
☐ Nerve damage ☐ Bowel/bladder incontinence ☐ Dizziness/blackouts ☐ Heart attack ☐ Depression
☐ Lung disease ☐ Kidney disease ☐ Heart disease ☐ Diabetes ☐ Gout
☐ High blood pressure ☐ Stomach ulcers ☐ Headaches ☐ Vision problems ☐ Cancer
☐ Hearing problems ☐ Stroke/TIA ☐ Osteoporosis ☐ Fibromyalgia ☐ COPD

Do you have a pacemaker? ☐ Yes ☐ No **Do you take blood thinners?** ☐ Yes ☐ No

Do you have any metal implants? ☐ Yes ☐ No **Are you pregnant?** ☐ Yes ☐ No

Unexplained weight loss or gain? ☐ Yes ☐ No **Fever, chills or night sweats?** ☐ Yes ☐ No

Allergies: ☐ Iodine ☐ Bees ☐ Tape ☐ Latex ☐ Other ______

Drug allergies to: ______

Other medical issues we should know about? ______

Please list any past illnesses, injuries or surgeries (with date) which required hospitalization: ______

______

In the past 2 weeks, how often have you been bothered by any of the following problems?

☐ Little interest or pleasure in doing things: ☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day
☐ Feeling down, depressed or hopeless: ☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day
☐ Would you like help with how you feel? ☐ Yes, today ☐ Yes, but not today ☐ No

Do you take medications (including nonprescription drugs)? ☐ Yes ☐ No If yes, please list below or attach a list.

Name of medication	Why you take it	Name of medication	Why you take it

Patient/authorized representative signature ______ **Relationship to patient** ______

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