MORRIS HOSPITAL
& HEALTHCARE CENTERS

People You Know. Extraordinary Care.

PHYSICAL REHABILITATION
Questionnaire

Thank you for taking the time to complete this questionnaire. It will assist your therapist in planning safe and effective treatment.

Name:_____________________________________ **Date:**_______________ **Sex: M F**

Age:______________ **Occupation:**__________________________________

Have you ever had any of the following medical problems? (check all that apply)

- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Stroke
- ☐ Circulation Problem
- ☐ Tuberculosis (TB)
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Cardiac Pacemaker
- ☐ Kidney Disease
- ☐ Other: ___________ __________________
- ☐ Total Joint Replacement
- ☐ Hepatitis
- ☐ History of Blood Clots
- ☐ Pneumonia
- ☐ Seizures
- ☐ Arthritis
- ☐ Ulcers
- ☐ Metal Implants
- ☐ Lung Disease/ Breathing Problems/ Asthma
- ☐ Eye Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Head Injury
- ☐ Psychiatric/ psychological problems

Allergies:

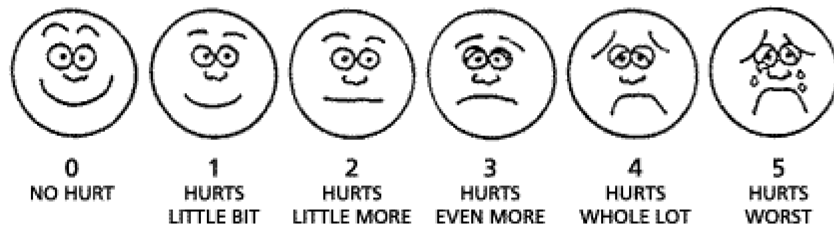
☐ To Iodine ☐ To Bees ☐ To Tape

Other:____________________________________

Female Only: Do you think you might be pregnant? Y N

Do you take medications (including non-prescription drugs – dietary supplements)?

Name of Medications	Dose/Frequency	For What?



What are the problems for which you are seeking therapy? How long have you had these problems?

List Problems	Length of Time

Have you ever had therapy or rehab for any of these problems in the past?

Type of Treatment	Where	Dates

What tests/procedures have been done so far for these problems? (Please note location of tests if other than Morris Hospital).

Name of test	Results	Dates

Has your physician placed you on any restrictions? (for example: lifting, exercise, weight bearing, braces, diet or thin liquids, etc.) Please List______________________

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____

____

What results do you expect from therapy? What are your goals? ________________

____

____

Date of accident/injury (if applicable): ____

Last day worked: (if applicable): ____

Doctors involved with case:____

Rehabilitation Specialist (case manager) or Nurse:_________________________________

Phone number of case manager/nurse:____

When is you next scheduled appointment with the physician who prescribed therapy?

______________________________________ Time:_____________________

____ _______________________

Signature (circle one): Patient Other Date: