MORRIS HOSPITAL & HEALTHCARE CENTERS
People You Know. Extraordinary Care.

***MORRIS HOSPITAL***
***Rehab Services Questionnaire***

1 O T H

**Thank you for taking time to complete this questionnaire. It will assist your Therapist in planning safe and effective treatment. Please be as accurate as possible.**

**Name:** _____ **Date:** _____ **Sex: M F**

**Age:** _____ **Occupation:** _____

**What problems are you seeking therapy for?**_____

_____

_____

## Have you ever had <u>any</u> of the following medical problems? (check and circle all that apply)

( ) Heart Disease, Heart surgery, CHF, chest pain, angina, pacemaker, AICD
( ) Breathing Problems, Shortness of breath, lung disease, Tuberculosis, Pneumonia, COPD, Asthma
( ) Circulation Problems, discolored or painful feet, lower extremity swelling
( ) Clots
( ) High/Low Blood Pressure
( ) Stroke
( ) Falls
( ) Pregnant-currently
( ) Psychological or Psychiatric conditions
( ) Dizziness/Vertigo
( ) Seizures
( ) Recent fever/chills/sweating
( ) Night pain
( ) Numbness/tingling groin region
( ) Recent changes to bowel/bladder habits
( ) Recent unexplained weight loss, weight gain
( ) Recent fracture
( ) Metal Implants
( ) Total Joint Replacements
( ) Head Injury
( ) Difficulty understanding directions
( ) Difficulty with memory
( ) Changes in hearing
( ) Changes in vision/eye disease/wears glasses
( ) Problems with swallowing or changes in speech
( ) Fibromyalgia
( ) Thyroid Disease/Metabolic conditions
( ) Arthritis: Rheumatoid/Osteoarthritis/Osteoporosis
( ) Parkinson ’s disease
( ) Diabetes/Neuropathy
( ) HIV/AIDS
( ) Multiple Sclerosis
( ) Infectious Disease
( ) Hepatitis
( ) Kidney Disease/Hemodialysis
( ) Cancer (where:_____) Do you currently have? Yes or No
( ) Headaches-frequent or severe
( ) Gastro intestinal disorders: Ulcers, GERD/heartburn, frequent nausea and vomiting

**Surgeries:**

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

**Allergies:**

( ) To Tape/Latex/Adhesives ( ) To food ( ) to medications ( ) to the environment ( ) lotion/fragrance
( ) Other _____

***Please continue to read page 2 and sign at bottom.***



Patient Label

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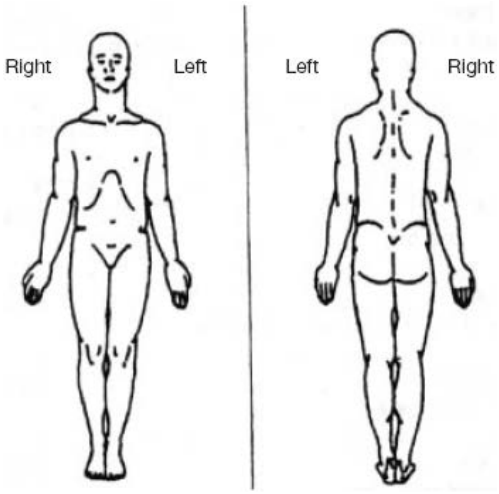
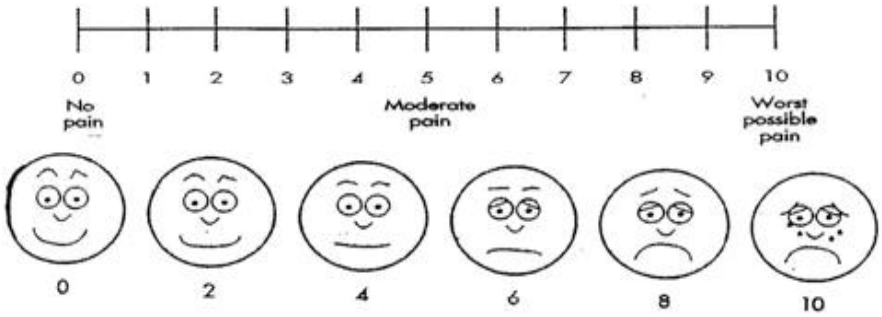
1 O T H

**Pain: Please indicate on pain diagram where your pain is located. Rate your pain below (0 = no pain & 10 = worse pain)**




**Pain currently: /10**
**Pain at worse: /10**
**Pain at best: /10**

**Describe your pain (circle all that apply):**
**Tender, dull, sharp, deep, aching, stabbing, throbbing, prickling, burning, stinging, itching, jabbing**

**Do you take medication (including over the counter medications/supplements)?**

| Name of medication | Dose/Frequency | For What: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**When is your next scheduled appointment with the physician who prescribed therapy? _____**

**What are your goals for therapy?_____**

_____

_____ _____

**Signature (circle one): Patient / Other** **Date**



Patient Label