Rehabilitation Medicine Clinic
Amputee Patient Questionnaire

(Please complete this 5-page form and bring to your appointment.)

Date_____**Appt. Date**_____ **Age**_____ **Date of Birth**_____
Name_____ ☐ **Male** ☐ **Female** **Hand dominance:** ☐ R ☐ L
Home Address_____ **Home Phone ( )**_____
_____ **Work Phone ( )**_____
City **State** **Zip** **Other Phone ( )**_____
Marital Status: ☐ Single ☐ Separated **Occupation**_____
☐ Married ☐ Widowed **If unemployed, how long?**_____☐ Mos ☐ Yrs
☐ Divorced ☐ Common Law **Education**_____
Medical Insurance Company: _____

Reason for clinic visit? List the 4 most important things that you would like us to help you with during your visit. This might include questions, concerns, or symptoms that need treatment.

1._____
2._____
3._____
4._____

Referring Provider_____ **Primary Care Doctor**_____
Address_____ **Address**_____
_____ _____
Phone ( )_____ **Phone ( )**_____
Fax ( )_____ **Fax ( )**_____

Please list any other health care providers you have:

Name & Specialty_____ **Name & Specialty**_____
Phone ( )_____**Fax ( )**_____ **Phone ( )**_____**Fax ( )**_____
Name & Specialty_____ **Name & Specialty**_____
Phone ( )_____**Fax ( )**_____ **Phone ( )**_____**Fax ( )**_____

Does your visit involve a legal case? ☐ **Yes** ☐ **No**
Lawyer's Name_____ **Allergies (medications & others):**
Phone ( )_____**Fax ( )**_____ _____
Address _____

List medical problems and surgeries (list year): **Current Medications:**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have Diabetes?_____ **Do you perform daily foot/skin checks?**_____
Diabetes provider (name/number)_____ **Do you have any skin breakdown or rashes? (where?)**
When was your last eye exam?_____ _____ _____

EvergreenHealth

Rehab Medicine Clinic
New Patient Questionnaire

Form ID REH___

APPLY PATIENT LABEL HERE

MD initials and
date:

Eye care provider (name/number)_____ **What soaps do you use?**_____

Review of Symptoms: Please mark (x) in the box if any of the following apply to you personally:

Yes Now	Yes Past	No	Neurologic/Psychiatric
☐	☐	☐	Weakness
☐	☐	☐	Change in sweating pattern
☐	☐	☐	Difficulty walking
☐	☐	☐	Fainting spells (blackouts)
☐	☐	☐	Lack of energy (fatigue)
☐	☐	☐	Loss of balance
☐	☐	☐	Loss of feeling in part of body
☐	☐	☐	Headaches
☐	☐	☐	Tremor (shaking, trembling)
☐	☐	☐	Trouble sleeping
☐	☐	☐	Anxiety
☐	☐	☐	Depression (feeling sad)
☐	☐	☐	Crying spells
☐	☐	☐	Excessive worry
☐	☐	☐	Memory trouble
☐	☐	☐	Trouble concentrating
			Eyes
☐	☐	☐	Blurry vision even with glasses
☐	☐	☐	Double vision (diplopia)
☐	☐	☐	Loss of vision in one eye
			Ears, nose, Mouth, Throat
☐	☐	☐	Dizziness
☐	☐	☐	Ear pain
☐	☐	☐	Hearing trouble
☐	☐	☐	Ringing in the ears (tinnitus)
☐	☐	☐	Trouble breathing through nose
☐	☐	☐	Sore mouth
☐	☐	☐	Teeth trouble
☐	☐	☐	Persistent hoarseness
☐	☐	☐	Voice change
☐	☐	☐	Swallowing trouble
			Heart
☐	☐	☐	Chest pain
☐	☐	☐	Strong heart beat (palpitations)
☐	☐	☐	Leg pain when walking
☐	☐	☐	Ankle swelling

Yes Now	Yes Past	No	Genitourinary
☐	☐	☐	Frequent urination
☐	☐	☐	Painful urination
☐	☐	☐	Trouble starting urine
☐	☐	☐	Trouble holding urine
☐	☐	☐	Urinate more than twice per night
☐	☐	☐	Blood in urine
☐	☐	☐	Sexual problems
☐	☐	☐	**(Males)** Erection difficulty
☐	☐	☐	**(Males)** Discharge from penis
☐	☐	☐	**(Males)** Problems with testicles
☐	☐	☐	**(Females)** Unusual vaginal bleeding/discharge
☐	☐	☐	**Bones/Joints**
☐	☐	☐	Joint pain
☐	☐	☐	Joint swelling
☐	☐	☐	Chronic low back pain
☐	☐	☐	Chronic neck pain
			Breasts
☐	☐	☐	Lumps or discharge
			Constitutional/Endocrine
☐	☐	☐	Unexplained weight loss or gain
☐	☐	☐	Intolerance of heat
☐	☐	☐	Intolerance of cold
☐	☐	☐	Night sweats
☐	☐	☐	Unexplained fever
			Allergy/Immunology
☐	☐	☐	Seasonal allergies (hay fever)
☐	☐	☐	Other infections_____
			Lymphatic/Hematologic
☐	☐	☐	Enlarged glands (neck, groin, under arms)
☐	☐	☐	Easy bruising or bleeding
			Stomach
☐	☐	☐	Frequent nausea and/or vomiting
☐	☐	☐	Vomiting blood
☐	☐	☐	Frequent stomach pain

APPLY PATIENT LABEL HERE

MD initials and date:

Lungs

- ☐ ☐ ☐ Daily cough
- ☐ ☐ ☐ Shortness of breath
- ☐ ☐ ☐ Coughing up blood

- ☐ ☐ ☐ Chronic constipation
- ☐ ☐ ☐ Chronic diarrhea
- ☐ ☐ ☐ Bowel habit change
- ☐ ☐ ☐ Blood in stool

Family Medical History (use extra page if needed)

Family Member	Year Of Birth	If living, list major medical problems	If not living, list age and cause of death
Mother			
Father			
Children			
Brothers Sisters			

Your Health Habits

Smoker: ☐ never ☐ current ☐ past # of years ____

Amount per day_____Year last quit _____

Alcohol: ☐ never ☐ current ☐ past # of years ____

Amount per week_____Year last quit _____

Other drug use (describe) _____

Hours of sleep per night _____

Number of meals per day _____

1. **Do you have any values or beliefs we should consider when planning your care?** ☐ Yes ☐ No
   If yes, please explain:_____

2. **Who do you live with?** (Check all that apply)
   ☐ I live alone ☐ Spouse / Partner ☐ Children ☐ Parents ☐ Currently homeless ☐ Other_____

   I live in a(n):
   ☐ Condo or Apartment
   ☐ House
   ☐ Assisted Living Facility

   (Check/circle all that apply)
   Which floor/# of floors:____
   Number of floors:_____
   ☐ Nursing Home

   Is there an elevator? Y N
   Split level? Y N
   ☐ Adult Family Home

   # of stairs to enter: ___
   # of stairs to enter: ___
   ☐ Retirement Center

   Are there railings? Y N On the: R L Both sides

   Shower/bath located on: Main level Upstairs level Basement

3. **Do you need help with transportation?**
   ☐ Family/Friends
   ☐ Escort
   ☐ No ☐ Yes If yes, check all that apply:
   ☐ Private Patient Transportation services (cabulance)
   ☐ Other_____

4. **Do you feel safe in your current living situation?** ☐Yes ☐No If no, please explain

5. **Are you currently experiencing any pain?** ☐ Yes ☐ No
   If yes, list the area and complete the scale below.
   Area of pain _____

Please rate your pain on a scale of 0 to 10. **Zero = no pain 10 = worst pain you have ever had.**

No pain **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

APPLY PATIENT LABEL HERE

MD initials and date:

What do you do to relieve your pain? _____

6. **Have you fallen in the past year?** ☐ Yes ☐ No
   - **If yes, why did you fall?** _____
   - **Were you injured?** ☐ Yes ☐ No
   - **Are you concerned that you could fall again?** ☐ Yes ☐ No

7. **Please describe your current functional abilities with the following:**

Level of assistance needed:	No help needed	1-25% assistance	26-50% assistance	51-75% assistance	76-99% assistance	100% assistance
Moving around in bed	☐	☐	☐	☐	☐	☐
Getting from laying down to sitting	☐	☐	☐	☐	☐	☐
Getting from sitting to standing	☐	☐	☐	☐	☐	☐
Walking indoors	☐	☐	☐	☐	☐	☐
Walking outdoors	☐	☐	☐	☐	☐	☐
Going up and down stairs	☐	☐	☐	☐	☐	☐
Using a wheelchair ☐ N/A	☐	☐	☐	☐	☐	☐
Putting on your shirt	☐	☐	☐	☐	☐	☐
Putting on your pants	☐	☐	☐	☐	☐	☐
Putting on your shoes/socks/ankle brace	☐	☐	☐	☐	☐	☐
Grooming (brush teeth/hair, shave, etc)	☐	☐	☐	☐	☐	☐
Showering/Bathing	☐	☐	☐	☐	☐	☐
Using the toilet or commode	☐	☐	☐	☐	☐	☐

When performing the above activities does someone need to be standing by you for safety or balance? ☐ Yes ☐ No

8. **Adaptive Equipment** (such as cane, walker, wheelchair, commode, shower bench/chair, reacher, AFO, prosthesis, etc).
   Please list items you currently use: _____
   _____

9. **Instrumental Activities of Daily Living** Because of a health or physical problem, do you have any difficulty with:

Activity	Yes	No
Using a telephone?	☐	☐
Doing light housework (like washing dishes, straightening up, dusting)?	☐	☐
Doing heavy housework (like scrubbing floors, washing windows)?	☐	☐
Preparing your own meals?	☐	☐
Shopping for personal items (like groceries, medicines, toiletries)?	☐	☐
Managing money (like keeping track of money, paying bills)?	☐	☐

10. **Are you currently driving?** ☐ Yes ☐ No
    Have there been any concerns raised by family members about your driving safety? ☐ Yes ☐ No

11. **Are you having a difficult time dealing emotionally with your current level of function?** ☐ Yes ☐ No

12. **Are you currently receiving any of these services?** (circle all that apply)
    Home Health Outpatient Therapies Rehab Without Walls Psychology

APPLY PATIENT LABEL HERE

MD initials and date:

Physical Therapy	Occupational therapy	Speech Therapy	Recreational Therapy
Visiting Nurse	Bath Aide	Paid Caregivers	Vocational counseling
Massage Therapy	Chiropractic Services	Acupuncture	Case Management/Social Work

Signature (Patient or Person Authorized to Sign) **Print Name** **Date**

If signed by person other than patient, please define your relationship to patient:

☐ Guardian ☐ Health Care Power of Attorney ☐ Parent

☐ Spouse/Registered Domestic Partner ☐ Adult child ☐ Other _____

I have reviewed this information.

Physician Signature	Print Name	Date

EvergreenHealth

Rehab Medicine Clinic
New Patient Questionnaire

APPLY PATIENT LABEL HERE

MD initials and date: