Northwestern Medicine Palos Hospital
Rehabilitation Therapy Services
PT/OT OUTPATIENT QUESTIONNAIRE

Thank you for filling out this questionnaire. It will assist your doctor/therapist in planning safe and effective treatment.

Name: ___________________________________ **Date of Birth:** ___/___/_____ **Today's Date:** _________________

What is your preferred language to discuss healthcare decisions? ☐ English ☐ Other: ____________________________________

Height: _______ **Weight:** ________ **Age:** _______ **Sex:** ☐ Male ☐ Female ☐ Right Handed ☐ Left Handed

Referring Physician: ________________________________ **Next appointment date with Physician:** ________________________

How did you hear about our services?

☐ Physician ☐ Website ☐ Family/Friend ☐ Newspaper/Ad ☐ Fitness Center ☐ Social Media

☐ Community Program (specify) ____________________________ ☐ Other: ___________________________

Have you received any Home Health Services in the past 30 days? ☐ Yes ☐ No If yes, explain: _______________________________

How often do you have problems learning about your medical condition because of difficulty understanding health information?

☐ Always ☐ Often ☐ Sometimes ☐ Occasionally ☐ Never

CURRENT CONDITION

Describe the current issue or recent surgery that brings you here today: ____

____

Date of Surgery/Onset of issue: ____

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

Has the 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 ☐ cough/sneeze ☐ turning neck/back ☐ reaching ☐ holding/gripping ☐ ___________________

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

☐ lying down ☐ sitting ☐ turning neck/back ☐ standing ☐ walking ☐ bending

☐ heat ☐ cold pack ☐ rest ☐ splinting ☐ medication ☐ ___________________

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 as a result of 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 & Needles

☐ Burning ☐ Sharp ☐ Dull

☐ Constant ☐ Come and Go ☐ Other ____________

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

☐ Morning ☐ Night ☐ Other ____________

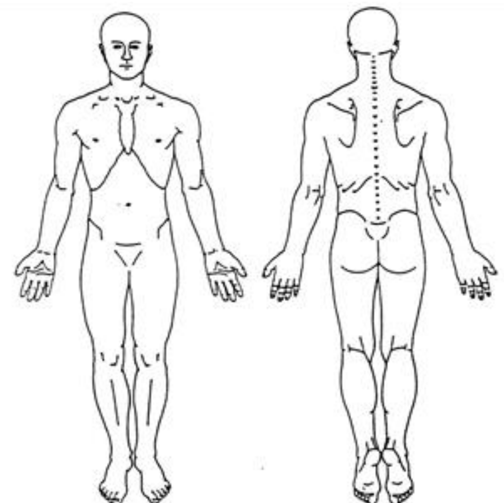
Does your pain progress as the day goes along? ☐ Yes ☐ No

Do you have difficulty falling asleep? ☐ Yes ☐ No

Do you wake due to the pain? ☐ Yes ☐ No

# of times per night _________

Mark the location of your pain with an "X"



FUNCTIONAL ABILITIES

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

☐ Squatting ☐ Sitting ☐ Driving ☐ Holding/Carrying Objects ☐ Work Tasks ☐ Gripping/Pinching
☐ Reaching ☐ Standing ☐ Walking ☐ Dressing/Grooming ☐ Stairs ☐ Position changes
☐ Kneeling ☐ Lifting ☐ Yardwork ☐ Grocery Shopping ☐ Cooking ☐ Cleaning
☐ Vacuuming ☐ Laundry ☐ Other ____________________

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

Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? _______ If yes, was there an injury involved? ☐ Yes ☐ No

Do you feel unsteady when standing or walking? ☐ Yes ☐ No Do you have worries 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 any of the following medical problems 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 **Are you on 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 ☐ To Bees ☐ To tape ☐ Latex ☐ Other ____________________

☐ **Drug Allergies to:** ____________________

Other medical issues we should know about? ____________________

Please list any past Illness/Operation/Injury (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're feeling? ☐ Yes – today ☐ Yes, but not today ☐ No

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

NAME OF MEDICATION/DRUG	FOR WHAT?	NAME OF MEDICATION/DRUG	FOR WHAT?

Patient/Authorized Representative Signature ____________________ **Relationship to Patient** ____________________