Cambridge Health Alliance

Rehabilitation Services Evaluation Questionnaire

1. To help your therapist understand your Past medical History, Please check either "Yes" or "No" for the items listed below. Please comment on the space below for checked items.

Yes	No		Yes	No	
☐	☐	Hearing/Vision Problems	☐	☐	Psychological Treatment
☐	☐	High Blood Pressure	☐	☐	Sensation Problems
☐	☐	Heart problems	☐	☐	Open Sores
☐	☐	Lung Diseases	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Medication Use
☐	☐	Surgery	☐	☐	MRI, CT Scan, X-ray
☐	☐	Cancer	☐	☐	Allergies
☐	☐	Car Accidents	☐	☐	Other:_____
☐	☐	Broken Bones	☐	☐	Other:_____
☐	☐	Traumatic Injury	☐	☐	Other:_____

Comments: _____

2. Please check below your current living situation:

☐ I live alone	☐ I have stairs at home with a railing
☐ I Live with family members	☐ I have stairs at home without a railing
☐ I live with Friends	☐ I presently do not have a home

3. Because Domestic Violence is common in many people's lives we ask all of our patients about it. Are you concerned for your safety at home?

☐ Yes ☐ No _____

4. To assist your clinician in understanding how you learn best can you check off what best describes your learning style: ☐ Demonstration

☐ Verbal Instruction ☐ Written Instruction ☐ Other: _____

5. What hobbies do you have that are potentially impacted by your current condition?

_____

6. ARE YOU PRESENTLY WORKING?

☐ YES ☐ NO NAME OF CURRENT JOB: _____

NUMBER OF HOURS PER WEEK: _____

7. DOES YOUR CURRENT PROBLEM WAKE YOU UP ON A REGULAR BASIS?

☐ YES ☐ NO _____

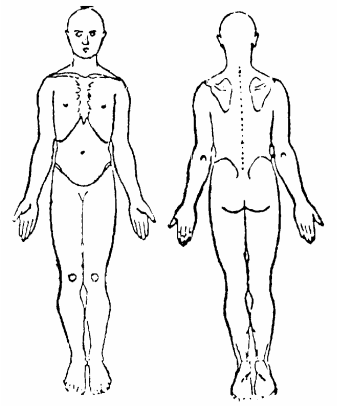
8. DOES YOUR CURRENT PROBLEM MAKE GETTING DRESSED DIFFICULT FOR YOU?

☐ YES ☐ NO _____

9. ON A SCALE OF 0 TO 10, CAN YOU PICK A NUMBER THAT BEST DESCRIBES THE YOUR PAIN ON AVERAGE?
0 IS NO PAIN AND 10 IS THE WORST PAIN YOU COULD EVER IMAGINE. PLEASE CIRCLE YOUR ANSWER:

0 1 2 3 4 5 6 7 8 9 10

10. WHERE IS YOUR PAIN? PLEASE USE THE PICTURE TO DRAW PAIN LOCATION.



_____

11. WHAT MAKES YOUR PAIN WORSE?

_____

_____

12. WHAT CAN YOU DO TO MAKE YOUR PAIN BETTER?

_____

_____

WE WANT YOU TO BENEFIT FROM YOUR THERAPY AS MUCH AS POSSIBLE. YOUR CLINICIAN WILL PROVIDE EDUCATION AND TREATMENTS THAT WILL HELP YOU RECOVER, BUT WITHOUT YOUR ACTIVE PARTICIPATION THERAPY ALONE MAY NOT BE ENOUGH. IT IS IMPORTANT THAT YOU UNDERSTAND HOW IMPORTANT YOUR INVOLVEMENT IS IN YOUR RECOVERY. PLEASE TAKE A MOMENT TO REVIEW THE ITEMS AND SIGN BELOW.

☑ CONTACT THE REHAB DEPARTMENT IF YOU ARE GOING TO BE LATE OR MISS AN APPOINTMENT.

☑ IF YOU DO NOT SHOW UP FOR TWO APPOINTMENTS WITHOUT CANCELING YOUR THERAPIST MAY DISHARGE YOUR CHART AND NOTIFY THE REFERRING DOCTOR.

☑ YOUR THERAPIST WILL CONDUCT A RE-EVALUATION AFTER EACH 30 DAYS OF TREATMENT.

☑ YOU AGREE THAT YOUR HOME EXERCISE PROGRAM IS AN IMPORTANT COMPONENT OF YOUR REHABILITATION AND AGREE TO PERFORM IT AS REQUESTED BY YOUR THERAPIST.

NAME: _____ DATE: _____

CLINICIAN: _____ DATE: _____