Name:		Ag	e:	Today's D)ate:		
Have you had any outpatient January 1 of this year? If yes, please describe:	YES 🗆 NO					•	
Date of initial Neurological D	agnosis:						
Initial Symptoms:							
Current Symptoms:							
Primary Care Doctor:		Neurol	ogist: _				
Do you have pain? ☐ YES	□ NO → If yes,	please rate your pain or	n the fol	llowing pain s	cale: (Circ	le the nur	mber.)
0 (none) 1 2	3	4 5	6	7	8	9	10 (Severe
If you do have pain, please w	rite where your pail	n is located:					,
Describe what you do to kee	p physically fit:						
Social Information:							
Do you live alone? Do	es vour home have	stairs? If ves	. how m	anv stairs?	Is ther	re a railind	ı?
Are you employed? If	-			-		_	
If you are no longer employe	d, what type of work	c did you do in the past?	·				
What household chores do y	ou participate in? _						
Do you drive?							
Do you use any type of assis	tive device such as	a walker or cane?					
Do you have any previous	history of the follo	wing conditions?					
Are you currently receiving a	-	_	□ NO				
Have you taken steroids for a	•		□ NO				
Have you had any tests in th	e past 6 to 12 mont	hs? (X-Ray, CT Scan, N	/IRI, EM	G, ECG, etc)			
Have you recently noted (wit	hin the past 3 mor	nths):					
Weight loss/gain	☐ YES ☐ NO		□Y	′ES □ NO			
Nausea/Vomiting	☐ YES ☐ NO	Fever/chills/sweats	□Y	′ES □ NO			
Dizziness/lightheadedness	☐ YES ☐ NO	Numbness or tingling	□Y	′ES □ NO			
Fatigue	☐ YES ☐ NO						
Languages you speak: ☐ E Preferred language for discu	•						
Preferred method of commun	nication: 🛚 Verbal	☐ Sign Language ☐ V	Vritten (□ Video □ O	ther:		
		→→→ OVER →→	→				



Olathe, Kansas 66061





PT / OT NEURO REHABILITATION **INTAKE QUESTIONNAIRE & OUTPATIENT SUMMARY** Page 1 of 3

O.M.C. No. 2229 9.25.2017; Rehab

In the sp	ace below, please tell us anything else you think your therapist will need to know:
	h of the following activities, please indicate your level of self-confidence by choosing a corresponding
	from the following rating scale: 0% 10 20 30 40 50 60 70 80 90 100 %
How co	onfident are you that you will not lose your balance or become unsteady when you
1.	Walk around the house?%
2.	Walk up or down stairs?%
3.	Bend over and pick up a slipper from the front of a closet floor%
4.	Reach for a small can off a shelf at eye level?%
5.	Stand on your tiptoes and reach for something above your head?%
6.	Stand on a chair and reach for something?%
7.	Sweep the floor?%
8.	Walk outside the house to a car parked in the driveway?%
9.	Get into or out of a care?%
10.	Walk across a parking lot to the mall?%
11.	Walk up or down a ramp?%
12.	Walk in a crowded mall where people rapidly walk past you?%
13.	Are bumped into by people as you walk through the mall?%
14.	Step onto or off an escalator while you are holding onto a railing?%
15.	Step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing?%
16.	Walk outside on icy sidewalks?%



09.0205



PT / OT NEURO REHABILITATION INTAKE QUESTIONNAIRE & OUTPATIENT SUMMARY Page 2 of 3

PATIENT LABE

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Past Medical History: Do you have ANY previous history of the things listed below? **CONDITIONS: CONDITIONS:** YES YES NO NO High Blood Pressure Pacemaker Heart Condition Seizures Cancer Stroke(s) Shortness of Breath Metal Implants Diabetes Asthma Dizziness Persistent Night Pain Frequent/Severe Headaches Light Headedness **Unexplained** Weight Loss **Excessive** Fatigue Broken Bones (fractures) Past or Current Bowel/Bladder dysfunction Gynecological Issues Fibromyalgia Vaginal/Cesarean Birth (Number: _ Arthritis Thyroid Problems Did you have any back pain with your pregnancy or after childbirth? Kidney Problems Blood Clots and/or Poor Circulation Other: Staff **ALLERGIES REACTION(S)** Date Time Initials Do you have any allergies? ☐ No ☐ Yes, please list: OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Staff Date Time **Initials** Do you have any other diagnoses &/or significant conditions? ☐ No ☐ Yes, please list: **PREVIOUS PROCEDURES / SURGERIES** Staff Date Time **Initials** Do you have any previous procedures or surgeries? \square No \square Yes, please list: **CURRENT MEDICATIONS** Staff ☐ See attached list of medications that the patient provided. Date Time **Initials** Are you currently taking any medications, including herbals? ☐ No ☐ Yes, please list: **INITIALS** STAFF SIGNATURE INITIALS **STAFF SIGNATURE** TIME: DATE: PATIENT SIGNATURE: PT / OT NEURO REHABILITATION 09.0205 **INTAKE QUESTIONNAIRE &**

Olathe Medical Center

20333 West 151st Street Olathe, Kansas 66061

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