NEWTON-WELLESLEY
AMBULATORY CARE CENTER
NEWTON

Rehabilitation Services
159 Wells Avenue
Newton, Massachusetts 02459
Tel: (617) 243-6172 • Fax: (617) 243-6651

Name:

Date of Birth: Today's Date:

MR Number:

MEDICAL STATUS QUESTIONNAIRE: REHABILITATION SERVICES

The purpose of this questionnaire is to assist us in understanding your current and past health status. Please complete both sides of this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

What is your primary language for reading and writing? English Other (Specify):_____

Are there any cultural/religious practices which should be considered in treatment planning?_____

What is your goal for therapy:_____

1. Have you ever been informed that you have:			**Comments/Update Therapist's Initials/Date**
High Blood Pressure?	Yes	No	
Heart Problems?	Yes	No	
Lung Problems?	Yes	No	
Kidney Problems?	Yes	No	
Head Injury?	Yes	No	
Multiple Sclerosis/ Parkinson's Disease?	Yes	No	
Stroke/ Neurological Problems?	Yes	No	
Liver Problems?	Yes	No	
Thyroid Problems?	Yes	No	
Blood Disorder?	Yes	No	
Diabetes (High Blood Sugar)?	Yes	No	
Low Blood Sugar?	Yes	No	
Seizures?	Yes	No	
Cancer?	Yes	No	
Arthritis?	Yes	No	
Tuberculosis?	Yes	No	
Repeated Infections?	Yes	No	
Osteoporosis?	Yes	No	
Circulation or Vascular Problems?	Yes	No	
Broken Bones (Fracture)?	Yes	No	
Ulcer/ Stomach Problems?	Yes	No	
For Men Only			
Prostate Disease?	Yes	No	
For Women Only			
Pelvic Inflammatory Disease?	Yes	No	
Endometriosis?	Yes	No	
Have you had a complicated pregnancy/ delivery?	Yes	No	
2. Have you recently had:			
Unexpected weight loss or gain?	Yes	No	
Unexplained Fever, Chills, or Sweats?	Yes	No	
Pain at Night?	Yes	No	
Fatigue/ Tiredness or Malaise?	Yes	No	

Name: DOB: MR Number:

3. Have you recently had (Continued):			Comments/Update Therapist's Initials/Date
Difficulty Sleeping?	Yes	No	
Joint pain and/or Swelling?	Yes	No	
Urinary or Bowel Problems?	Yes	No	
Nausea and Vomiting?	Yes	No	
Numbness or Tingling?	Yes	No	
Weakness in your Arms or Legs?	Yes	No	
Coordination Problems?	Yes	No	
Difficulty Walking?	Yes	No	
Dizziness or Loss of Consciousness?	Yes	No	
Loss of Balance?	Yes	No	
One or more falls in the last 3 months?	Yes	No	
Worries or concern about falling?	Yes	No	
Chest Pain?	Yes	No	
Heart Palpitations?	Yes	No	
Shortness of Breath?	Yes	No	
Difficulty Swallowing?	Yes	No	
New Onset of Headaches?	Yes	No	
Visual Problems?	Yes	No	
Hearing Problems?	Yes	No	
Hoarseness?	Yes	No	
Cough?	Yes	No	
Sexual Dysfunction?	Yes	No	
4. Do You?			
Smoke? If yes, how much? _____ packs/day	Yes	No	
Have a significant family history of cardiopulmonary illness or disease?	Yes	No	
Have any other medical problems? If so, what?	Yes	No	
Do you receive other services here or elsewhere?	Yes	No	

5. Current Medications/ Drugs (Please list all, including herbals and over the counter)			Known allergies or reactions to medications
A.	B.	C.	
D.	E.	F.	
G.	H.	I.	

6. Previous Surgeries/ Hospitalizations	Date	Reason:
A.		
B.		
C.		

7. Have you recently had any of the following tests? If Yes, please circle all that apply.

A. X-Rays B. CT Scans C. MRI D. Bone Scan E. Myelogram F. Blood Tests

G. EKG H. EMG I. Stress Test J. Pulmonary Function Test Other:_____

8. Have you seen anyone else for the problem for which you have been referred? If Yes, please circle all that apply.

A. Physician B. Dentist C. Podiatrist D. Osteopath E. Physical/Occupational Therapist F. Chiropractor G. Other

9. Have you recently received other treatments? If yes, please circle all that apply. Yes No	When were you last seen by a physician?
A. Chemotherapy B. Injection C. Other	Are your immunizations current? Yes No
10. Who is the physician you see most often? NWH	Address:

Therapist Signature: Date: Time: