



Dear St. Francis Rehab and Sports Medicine Patient:

Thank you for choosing St. Francis Rehab and Sports Medicine for your physical, occupational, and/or speech-language pathology needs. Our goal is to deliver peak care with you at the center of the treatment plan. Our highly trained team will consider your individual needs and will develop a treatment plan personalized to you and your condition. Therapy plans may vary and will include education, fitness, and activity modification components. Rehabilitative services are designed to be active in nature. To achieve optimal results, active treatment assumes that you, as the individual, will adhere to the plan that was discussed with your therapist. Questions throughout your therapy sessions are encouraged as we understand that most of the information we are giving you is new. There is a number of research studies suggesting that the more informed you are, the better your outcome will be.

Again, I would like to thank you for allowing us to participate in your care. We appreciate and value your feedback and opinions. You will receive an email survey asking about your care at St. Francis Rehab and Sports Medicine. Please take the time to give us your thoughts. If you are unable to grade our services as exceptional, I would like to hear why so that we may improve your experiences in the future.

Sincerely;

Jeff Foss MSPT

General Manager

## Patient Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F \_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Alternative Phone #: \_\_\_\_\_

Email address: \_\_\_\_\_ Would you like to receive mail/e-mails from us? Y N

Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_

**What are we seeing you for today?** \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_

Primary Doctor (if different from referring): \_\_\_\_\_ Phone: \_\_\_\_\_

When was your first MD appt? \_\_\_\_\_ Last MD appt? \_\_\_\_\_ Next MD appt? \_\_\_\_\_

Have you had an x-ray, MRI, CT-scan, or any other type of diagnostic procedure? \_\_\_\_\_

If yes, when & where were these test taken at? \_\_\_\_\_

Have you had any injections? Y / N If yes, when and where? \_\_\_\_\_

Have you had any surgeries related to your current diagnosis? Y / N

Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Where? \_\_\_\_\_

Have you experienced broken bones? Y / N Was it related to this diagnosis? Y / N

Describe your pain: \_\_\_\_\_ Constant \_\_\_\_\_ Intermittent \_\_\_\_\_ Dull \_\_\_\_\_ Sharp \_\_\_\_\_ Burning

Location of this pain: \_\_\_\_\_

Rate your pain (0= no pain, 10= worst possible pain): Today's pain: \_\_\_\_\_ Worst pain (date): \_\_\_\_\_ Best pain (date): \_\_\_\_\_

Is this pain keeping you awake at night? Y / N

Do you exercise regularly or participate in sports/recreational activities? Y / N

If so, what are these and how often per week and what duration: \_\_\_\_\_

Currently working? Y/N Hours per week? \_\_\_\_\_ Employer (if applicable): \_\_\_\_\_

Occupation: \_\_\_\_\_ Working Positions: \_\_\_\_\_ % standing \_\_\_\_\_ %walking \_\_\_\_\_ % sitting

Employer (if applicable): \_\_\_\_\_

Is this a worker's compensation injury? Y / N

Is this an auto accident? Y / N

*If you've answered "yes" to either of the above questions, please provide our office of your current claim information and any additional information that is relevant to your care*

How and when did this accident occur? \_\_\_\_\_  
\_\_\_\_\_

**What are your goals for therapy?** \_\_\_\_\_

Allergies: \_\_\_\_\_ Reactions: \_\_\_\_\_

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Surgical/Medical History (past and present):

\_\_\_\_\_ HBP      \_\_\_\_\_ Pacemaker      \_\_\_\_\_ Stroke      \_\_\_\_\_ Cancer      \_\_\_\_\_ Fractures

\_\_\_\_\_ Heart Disease      \_\_\_\_\_ Metal Implants      \_\_\_\_\_ Pregnancy      \_\_\_\_\_ Diabetes      \_\_\_\_\_ Seizures

\_\_\_\_\_ Hearing Issues      \_\_\_\_\_ Visual Issues      \_\_\_\_\_ Infectious disease

\_\_\_\_\_ Other \_\_\_\_\_

Surgeries (include dates): \_\_\_\_\_

Medications (include dosages): \_\_\_\_\_

How did you hear about St. Francis Rehab & Sports Medicine Clinics? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_