Northeast Hospitals
The Center for Rehabilitation and Sports Medicine

Label

Ambulatory Summary Questionnaire

GENERAL INFORMATION

What is the problem that brings you to therapy?
_____
_____
What are your goals for treatment?
_____
_____

Is your condition due to: ☐ Auto accident ☐ Fall ☐ Work injury ☐ Other_____
Date of onset: _____

Have you seen anyone else for your current problem? Check all that apply.
☐ Physical Therapist ☐ Occupational Therapist ☐ Massage Therapist
☐ Speech Therapist ☐ Chiropractor ☐ Acupuncturist
☐ Pain Management ☐ Other _____

Please check all diagnostic tests that you have had for your current problem only.
☐ EEG ☐ EMG ☐ CT scan ☐ Myleogram
☐ MRI ☐ X-ray ☐ Bone scan ☐ Other_____

Have you fallen in the past 12 months? _____If yes, how many times? _____
Do you currently use a mobility device? ☐ Yes ☐ No If yes, please check all that apply

☐ **brace** ☐ **cane** ☐ **crutches** ☐ **walker** ☐ **rolling walker** ☐ **scooter** ☐ **wheelchair**

Do you have any condition that would make learning difficult for you? ☐ Yes ☐ No
(i.e. hard of hearing, memory problems, reading or language difficulties, vision problems)
If yes, please specify_____
How do you learn the best? _____

SOCIAL HISTORY
What is your occupation? _____
Working Status: ☐ Working ☐ Light duty ☐ Disabled ☐ Retired
Smoking History: ☐ Never ☐ Quit (when_____) ☐ Smoking (_____pack/day)
Alcohol Intake: ☐ Never ☐ Socially ☐ Moderately ☐ Daily
Exercise: ☐ Yes ☐ No If yes, please list what you are doing and how frequently
_____
_____

Have you ever been diagnosed with an addictive disorder? ☐ Yes ☐ No If yes, please explain _____
_____

Known Allergies:	Adverse Reaction to Medication:
_____	

CURRENT MEDICATIONS Include over the counter medications / herbal remedies

Drug	Dosage/Frequency	Purpose

MEDICAL/SURGICAL HISTORY

	Yes	No	Comments		Yes	No	Comments
Circulation/Vascular				Asthma			
Blood Pressure				Tuberculosis			
Diabetes				Cancer			
Arthritis				Thyroid			
Kidney/Urinary				Dizziness			
Heart Disease				Epilepsy/Seizures			
Pacemaker				Respiratory			
Stroke				Skin Problems			
Parkinson's Disease				Pregnancy			
Neurological Disease				Osteoporosis			
Depression/Psychiatric				Stomach/GI			
Visual impairment				Other			
Last eye exam				Other			

List prior hospitalizations or surgeries that you have had

Date	Facility	Procedure/Purpose

OTHER

Do you have problems with	Yes	No	Comments	Do you have problems with	Yes	No	Comments
Bowel/bladder control				Sleeping			
Swelling /edema				Fatigue			
Headaches				Weight loss / gain			
Blurry/Double vision				Chest pain			
Nausea / vomiting							

Name of person completing form:_____ Date_____

_____

Clinician Signature Comments/Changes to form Date

_____

Clinician Signature Comments/Changes to form Date

_____

Clinician Signature Comments/Changes to form Date

BOLD = Fall Risk