Samaritan Medical Center

Watertown, NY

REHABILITATION SERVICES DEPARTMENT INTAKE QUESTIONNAIRE

What are you having problem(s) with? :

_____

_____

When did the problem(s) begin? :

_____

_____

Have you had any tests or surgery for the problem(s)? :

_____

_____

From the beginning of the current year, have you had any previous therapy for your current problem and/or any other problem(s)? :

_____

_____

List all medical problem(s)you have :

_____

_____

_____

List all medications you are currently taking :

_____

_____

_____

Are you receiving services through Jefferson County Public Health or Mercy Home Care? _____ If yes, you may be unable to receive therapy services through SMC.

Are you in pain now? :_____

Where? : _____

How Much? : (Please Circle)

0--------1---------2---------3---------4--------- 5 --------6--------7----------8----------9-------10

No Pain Worst Pain

Pain feels like? : _____

Do you have pain all the time or does it come and go? : _____

What make your pain worse? : _____

What makes your pain better? : _____

Does pain wake you up from sleeping? : _____

What is your goal for therapy? : _____

When is your next scheduled visit with your physician? :_____

Patient Signature: _____ Date: _____

Therapist Signature/Title: _____Date: _____