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

ST. FRANCIS
Rehab & Sports Medicine

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:_____

Allergies:_____ Reactions:_____

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:_____

_____

_____

_____