

**SOUTHWEST ADVANCED NEUROLOGICAL REHABILITATION, LLC**  
**PATIENT QUESTIONNAIRE**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: (        ) \_\_\_\_\_ Email: \_\_\_\_\_

**CAREGIVER INFORMATION**

Name: \_\_\_\_\_ Phone: (        ) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Email: \_\_\_\_\_

**TYPE OF INJURY**

- Stroke    Side of body affected:  Right  Left    Dominant Hand Prior to stroke:  Right  Left  
Date of stroke: \_\_\_\_\_ Type of stroke \_\_\_\_\_
- Traumatic brain injury    Date of brain injury \_\_\_\_\_
- Other: \_\_\_\_\_

**WALKING AND BALANCE**

Are you able to walk?	Yes	No	Do you use a wheelchair?	Yes	No
Do you use a walker?	Yes	No	Do you use a cane?	Yes	No
Do you use a leg brace?	Yes	No			
Have you fallen in the past year?	Yes	No	In the past month?	Yes	No

If so, when? \_\_\_\_\_

Have you stumbled recently or are you fearful of falling?    Yes    No

If yes, please explain: \_\_\_\_\_

**OTHER INFORMATION**

Do you need any help for the following activities?

Getting in/out of bed	No	Yes	How much	_____
Getting dressed / undressed	No	Yes	How much	_____
Toileting	No	Yes	How much	_____
Eating	No	Yes	How much	_____
Preparing food	No	Yes	How much	_____
Showering / bathing	No	Yes	How much	_____

Do you drive?    Yes    No    If no, do you want to drive?    Yes    No

Do you use your affected arm for anything? Describe \_\_\_\_\_

Pre stroke recreation and hobbies \_\_\_\_\_

Medications:

_____	for what	_____
_____	for what	_____
_____	for what	_____
_____	for what	_____
_____	for what	_____
_____	for what	_____

HEALTH INFORMATION

Please mark if you have a history of any of the following conditions.

Heart Disease	Yes	No	Cancer	Yes	No
Hypertension	Yes	No	Depression	Yes	No
Pulmonary Disease	Yes	No	Diabetes	Yes	No
Head injury or surgery	Yes	No			
Thyroid Disease	Yes	No	Expressive Aphasia	Yes	No
Seizures	Yes	No	Receptive Aphasia	Yes	No
Allergies, Asthma	Yes	No	Anemia (blood problems)	Yes	No

Other: \_\_\_\_\_

If you answered yes to any of the above, please explain \_\_\_\_\_

**WHAT ARE YOUR GOALS FOR THERAPY?**

Walking and balance goals

_____	_____
_____	_____
_____	_____

Arm and Hand Goals

_____	_____
_____	_____
_____	_____

Signed: \_\_\_\_\_ Date \_\_\_\_\_