Are there any new medical issues since last seen at the IRCP? Y/N

If yes, please describe:

How many falls have you had in the last year? _____

Have any of these falls resulted in an injury? Y/N

If yes, please describe:

How often do you stumble or trip without falling? (daily, weekly, monthly)

Are you experiencing increased weakness/fatigue since you were last seen at the IRCP? Y/N

If yes, please describe:

Do you have pain? Y/N

Where?

Please describe:
Do you have any problems with swallowing pills or food, choking or food not going down easily? Y/N
If yes, please describe: ___________________________________________________________

Does your voice get tired or weak? Y/n
If yes, please describe: _________________________________________________________

Do you wear a brace? Y/N
When was the last time it was replaced? __________________________________________
Are there any issues with you brace (discomfort, skin breakdown, broken parts, etc.)? Y/N
If yes, please describe: _________________________________________________________

Are there any changes to your work status or home environment? Y/N
If yes, please describe: _________________________________________________________

Are there any activities you are unable to do now that you could do at your last visit to the IRCP?
______________________________________________________________________________
______________________________________________________________________________

What would you like us to help with on your return visit to the IRCP? _______________
______________________________________________________________________________
______________________________________________________________________________
**PATIENT INTAKE FORM**

Name: ______________________

What condition brings you to therapy (in your own words)?: _______________________________________

**MEDICAL HISTORY:**
Prior surgeries/injuries? _______________________________________
Recent hospital visits or stays? _______________________________________

List ALL Allergies

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List all CURRENT Medications/Supplements

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☐ Check if you have fallen in the past 3 months.
☐ Check if you are currently pregnant.

Check ALL the medical conditions that apply to you

<table>
<thead>
<tr>
<th>Medical Condition</th>
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<th>Medical Condition</th>
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<tbody>
<tr>
<td>Allergic rhinitis</td>
<td>Genital Herpes</td>
<td>Neuropathy</td>
</tr>
<tr>
<td>Anemia</td>
<td>GERD</td>
<td>Obesity</td>
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<tr>
<td>Anxiety</td>
<td>Glaucoma</td>
<td>Osteopenia</td>
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<tr>
<td>Arthritis</td>
<td>Headache-migraine</td>
<td>Pneumonia</td>
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<tr>
<td>Asthma</td>
<td>Heart Disease</td>
<td>Pregnancy</td>
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<tr>
<td>Back Injury</td>
<td>Heart Murmur</td>
<td>PUD</td>
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<tr>
<td>Cancer</td>
<td>Hepatitis</td>
<td>Pulmonary Embolism</td>
</tr>
<tr>
<td>CHF</td>
<td>HIV/AIDS</td>
<td>Recurrent URI</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>HPV Infection</td>
<td>Seizure Disorder</td>
</tr>
<tr>
<td>Concussion</td>
<td>Hypertension</td>
<td>Skin Disease</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>Hypoglycemia</td>
<td>Sleep Apnea</td>
</tr>
<tr>
<td>Chrohn's disease</td>
<td>Incontinence</td>
<td>Stroke</td>
</tr>
<tr>
<td>Depression</td>
<td>Lung Disease</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Developmental/growth problems</td>
<td>Myocardial Infarction</td>
<td>Thyroid Disease</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Neck Injury</td>
<td>Ulcerative Colitis</td>
</tr>
<tr>
<td>Enlarged Prostate</td>
<td>Nerve/Muscle Disease</td>
<td>Vascular Disease</td>
</tr>
<tr>
<td>Fractures</td>
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</table>

☐ Check if you have been the victim of physical, sexual or verbal abuse in the past 12 months.
☐ Check if you feel unsafe at home due to abuse and neglect.
☐ Check if you are a parent or guardian completing this form on behalf of a patient.
Fatigue Severity Scale (FSS)

Your Name: _____________________________

Date: ______________________ Date of birth: _____________________

This questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

***A low value (e.g. 1) indicates strong disagreement with the statement, whereas a high value (e.g. 7) indicates strong agreement.

During the past week, I have found that:

1. My motivation is lower when I am fatigued

2. Exercise brings on my fatigue.

3. I am easily fatigued.

4. Fatigue interferes with my physical functioning.

5. Fatigue causes frequent problems for me.

6. My fatigue prevents sustained physical functioning.

7. Fatigue interferes with carrying out certain duties and responsibilities.

8. Fatigue is among my three most disabling symptoms.

9. Fatigue interferes with my work, family or social life.

Disagree ←———> Agree

1  2  3  4  5  6  7

Total Score: ____________
Great
Life is so-so.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

---

Now, where are you? Circle a number on the figure below that best describes your overall QOL.

One (1) means life is very distressing; it's hard to imagine how it could get much worse.

Seven (7) means life is great; it's hard to imagine how it could get much better.

Four (4) means life is so-so; neither good nor bad.
THE ACTIVITIES-SPECIFIC BALANCE CONFIDENCE (ABC) SCALE

Patient name: ___________________________ Date: ___________________________

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

How confident are you that you will not lose your balance when you:

1. Walk around the house?  
   No Confidence  Complete Confidence
   0% 10 20 30 40 50 60 70 80 90 100%

2. Walk up and down the stairs?  

3. Bend over and pick up a sipper from the front of the closet door?  

4. Reach for a small can off a shelf at eye level?  

5. Stand up on tip toes and reach for something above your head?  

6. Stand on a chair and reach for something?  

7. Sweep the floor?  

8. Walk outside the house to a car parked in the driveway?  

9. Get into or out of a car?  

10. Walk across the parking bl to a mall?  

11. Walk up or down a ramp?  

12. Walk in a crowded mall where people rapidly walk past you?  

13. Are bumped into by people as you walk through the mall?  

14. Step onto or off of an escalator while you are holding onto a railing?  

15. Step onto or off an escalator while you are holding onto parcels such that you cannot hold onto the railing?  

16. Walk outside on icy sidewalks?  