SPAULDING™
INTERNATIONAL REHABILITATION CENTER FOR POLIO
FRAMINGHAM

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? _____

_____

_____

SPAULDING
OUTPATIENT CENTERS

Patient Information:

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

List all CURRENT Medications/Supplements

☐ 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

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

☐ 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:	Disagree ⟷ Agree
1. My motivation is lower when I am fatigued	1 2 3 4 5 6 7
2. Exercise brings on my fatigue.	1 2 3 4 5 6 7
3. I am easily fatigued.	1 2 3 4 5 6 7
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me.	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 6 7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 6 7
9. Fatigue interferes with my work, family or social life.	1 2 3 4 5 6 7

Total Score: _____

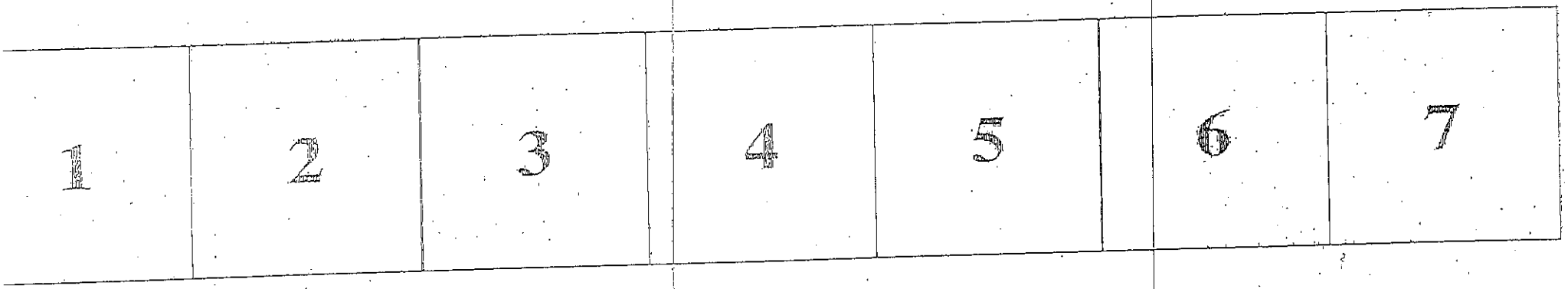
structions: Taking everything in your life into account, please rate your overall Quality
Life (QOL) on the following 7 point scale.

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

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.

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



ife is very
istressing.

Life is so-so.

Life is
great.

SPAULDING™
INTERNATIONAL REHABILITATION CENTER FOR POLIO

FRAMINGHAM

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:

	No Confidence 0%	10	20	30	40	50	60	70	80	90	Completely Confident 100%
1. Walk around the house?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Walk up and down the stairs?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Bend over and pick up a slipper 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 lot 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?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

* *Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1); M28-34.*