

MediSys Rehabilitation, Inc.

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Follow-Up Interview Questionnaire

Name of Patient: _____ Date of re-interview: _____

I. DAILY ACTIVITIES:

Have there been any changes in your condition since we saw you?

What limitations, if any, do you have with regard to activities of daily living (e.g., dressing, grooming, hygiene, toileting)?

What is your spouse/family member having to assist you with?

How has your role in your household changed?

Can you drive a car? Yes No

Can you manage your finances? Yes No

II. OCCUPATIONAL HISTORY:

Are you currently employed? Yes No

Are you on medical leave? Yes No

If working: When were you released to return to work? _____

Current job title: _____

List any physical or mental limitations you have in your job: _____

III. TREATING PROVIDERS:

Identify the physician(s) or treating provider(s) who is/are most familiar with your recent problems. **(If they recommended surgery/rehab, be sure to indicate if it has been scheduled/in progress and with who/when/where/frequency, etc.)**

1. Name of physician/provider: _____ **Specialty:** _____

Address: _____

Phone: _____ **Frequency Seen:** _____

Most recent treatment recommendation(s): _____

2. Name of physician/provider: _____ **Specialty:** _____

Address: _____

Phone: _____ **Frequency Seen:** _____

Most recent treatment recommendation(s): _____

3. Name of physician/provider: _____ **Specialty:** _____

Address: _____

Phone: _____ **Frequency Seen:** _____

Most recent treatment recommendation(s): _____

4. Name of physician/provider: _____ Specialty: _____
 Address: _____
 Phone: _____ Frequency Seen: _____
 Most recent treatment recommendation(s): _____

5. Name of physician/provider: _____ Specialty: _____
 Address: _____
 Phone: _____ Frequency Seen: _____
 Most recent treatment recommendation(s): _____

IV. CURRENT MEDICATIONS:

Please list all medications taken at present, the reason you're taking it, the dosage, the frequency, and whether or not it is helping. **Include all over the counter medications. (Also, if prn, still need dosage/how often/when).**

Name of Medication	Reason for taking	Dosage	Frequency	Outcome (is it helping?)

V. PSYCHOSOCIAL HISTORY:

With whom are you now living? _____

Do you live in a House Apartment Hotel Other: _____

Current address: _____

Location: Rural Urban Suburban

Describe current architectural barriers, if any: _____

Financial Status:

Are you making ends meet? Yes No

Do you receive (or have you received) any state-funded services (i.e., state vocational rehabilitation or employment services) or have you received charitable funds? If **yes**, describe: _____

Have you required outside services to maintain your home (i.e., maid service for cleaning, yard service)? If **yes**, describe: _____

If **yes**, how frequent are these services? _____ How much does it cost? _____

Psychological/Psychiatric Services:

Are you under the care of a psychiatrist, psychologist, or counselor? Yes No

If **yes**, name of doctor/therapist: _____

Have you had a prior psychological or neuropsychological evaluation? Yes No

If **yes**, name of psychologist: _____

Address: _____ Phone: _____

VI. SYMPTOM SURVEY:



0 1 2 3 4 5 6 7 8 9 10
Not at all ----- Mild ----- Moderate ----- Severe ----- Extreme

AREA	EXAMPLE	NUMERIC RATING
Problem Solving	Planning, multitasking, following steps	
Speech, Language, Academic Skills	Speaking, writing, speech, math, spelling	
Concentration and Awareness	Distraction, concentration, confusion	
Memory	Forgetfulness, relying on lists, needs cueing	
Motor and Coordination	Dressing, writing, ADL's, balance, reaction	

