Physical Therapy Consultants, Inc.

PATIENT QUESTIONNAIRE

As a rehabilitation agency, Physical Therapy Consultants, Inc. is required to evaluate the social and vocational needs of each of our patients. Please answer the following questions to the best of your ability.

	Question		
1.	Has your injury or illness produced a financial hardship for you or other members of your family?	YES	NO
2.	Has your injury or illness isolated you from your friends or family?	YES	NO
3.	Has your injury or illness caused you to receive assistance?	YES	NO
4.	If not, do you need assistance?	YES	NO
5.	Would you like information on finding assistance?	YES	NO
6.	As a consequence of your injury or illness, do you feel vulnerable or threatened by friends, family members, or others?	YES	NO
7.	As a result of your injury or illness, do you have thoughts of harming yourself or others?	YES	NO
8.	If you answered yes to any of the above questions, would you be Interested in meeting with a member of Social Services or Vocational Rehabilitation Services?	YES	NO
9.	Are there any other issues we haven’t addressed? (if yes, please explain below)	YES	NO

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____ ____________________

Patient Signature **Date**

For Office Use Only

______ Patient will be referred to Minnesota Workforce Center for Vocational Rehabilitation Services.

______ Patient will be referred to Anoka County Social Services.

______ Patient does not require either Vocational Rehabilitation nor Social Services assessment.

____ ____________________

Physical Therapist, License Number Date

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Signature of Social Worker/Psychologist Date

Updated September 22, 2006