cereneo
CENTER FOR NEUROLOGY & REHABILITATION

Patient questionaire admission

Patient Information

surname, name	date of birth	nationality
street	ZIP code & place	phone
email	height in cm	weight in kg

native language	other languages

Condition/disease for medical stay *(please tick accordingly)*

stroke	traumatic brain injury	Multiple Sclerosis	spinal injury	Parkinson's disease

other disease	

condition / disease exists since	Is the patient in possession of a COVID-certificate? ☐ yes ☐ no

Details of medical stay

desired entry date:	desired exit date:

Pre-existing diseases (e.g. cardiovascular, lung, diabetis, etc.)

Details of confidant

surname, name	date of birth	nationality
street	ZIP code & place	phone
email		

Medical attendant	Private attendant
number of medical attendants	number of private attendants

tasks of the medical attendants

Medical information *(please tick accordingly)*

Does the patient need ventilation? ☐ yes ☐ no	Does the patient need oxygen? ☐ yes ☐ no / If so, how much?
Is the oxygen saturation required to be monitored? ☐ yes ☐ no / ☐ day ☐ night	Any other severe accidents or diseases?
Does the patient have any artificial joints? ☐ yes ☐ no / If so, where:	

Mobility *(please tick accordingly)*

Weakness or abnormal rigidity of arm yes ☐ no ☐ / left arm ☐ right arm ☐	**Weakness or abnormal rigidity of foot** yes ☐ no ☐ / left foot ☐ right foot ☐
Extent of weakness or abnormal rigidity of arm ☐ mild ☐ moderate ☐ severe	**Extent of weakness or abnormal rigidity of foot** ☐ mild ☐ moderate ☐ severe
Weakness or abnormal rigidity of trunk yes ☐ no ☐	**Weakness or abnormal rigidity of head / neck** yes ☐ no ☐
Extent of weakness or abnormal rigidity of trunk ☐ mild ☐ moderate ☐ severe	**Extent of weakness or abnormal rigidity of head / neck** ☐ mild ☐ moderate ☐ severe

Perception & Speech *(please tick accordingly)*

	no	mild	moderate	severe
Impairment of spatial orientation				
pain or emotional disorder				
Impairment of perception / consciousness				
Impairment of swallowing				
Impairment of cognition / memory				
Impairment of speech				
Impairment of language				
Impairment of linguistic understanding				
is able to communicate her- / himself				

Activities of daily living *(please tick accordingly)*

eating & drinking essential aids: ☐ tube in stomach ☐ gastric tube		independent
		Independent with special tools
		nutrition must be prepared & assistance is needed
		completely dependent
Personal hygiene (bathing, grooming)		independent
		with guidance of a care giver
		needs support by a care giver / number of required care givers: ___
		completely dependent / number of required care givers: ___

Dressing		independent
		with guidance of a care giver
		needs support by a care giver / number of required care givers: ___
		completely dependent / number of required care givers: ___
Mobility		independent
		with aids independently possible (e.g. walking stick, ortheses, rollator, wheelchair)
		requires assistance for walking
		can NOT move independently (e.g. wheelchair)
		Is bedridden and a care giver is needed for repositioning
Required aids ☐ no aids		glasses, contact lenses
		walking stick / cane
		rollator / walker
		orthoses, for:
		wheelchair
		others:
Bladder and toilet use		completely continent
		occasional incontinence, independent cleaning & change of pants/sanitary napkins: ☐ urine / ☐ stool
		often incontinent, needs support to clean & change pants / sanitary napkins: ☐ urine / ☐ stool
		completely incontinent required aids: ☐ permanent catheter / ☐ pants / ☐ urinal condom

Support through care givers *(please tick accordingly)*

no ☐	yes ☐ At what times?	Care giver on call ☐ At what times?	1:1 support ☐ At what times?
Care giver:	☐ only female	☐ only male	☐ does not matter

Objectives of the patient