

## Patient questionnaire admission

Patient Information				
surname, name		date of birth		nationality
street		ZIP code & place		phone
email		hight in cm		weight in kg
native language			other languages	
Condition/disease for medical stay <i>(please tick accordingly)</i>				
stroke	traumatic brain injury	Multiple Sclerosis	spinal injury	Parkinson's disease
other disease				
condition / disease exists since				
Details of medical stay				
desired entry date:			desired exit date:	
Pre-existing diseases (e.g. cardiovascular, lung, diabetes, 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				

<b>Medical information</b> <i>(please tick accordingly)</i>				
Does the patient need ventilation? <input type="checkbox"/> yes <input type="checkbox"/> no		Does the patient need oxygen? <input type="checkbox"/> yes <input type="checkbox"/> no / If so, how much?		
Is the oxygen saturation required to be monitored? <input type="checkbox"/> yes <input type="checkbox"/> no / <input type="checkbox"/> day <input type="checkbox"/> night		Any other severe accidents or diseases?		
Does the patient have any artificial joints? <input type="checkbox"/> yes <input type="checkbox"/> no / If so, where:				
<b>Mobility</b> <i>(please tick accordingly)</i>				
<b>Weakness or abnormal rigidity of arm</b> yes <input type="checkbox"/> no <input type="checkbox"/> / left arm <input type="checkbox"/> right arm <input type="checkbox"/>		<b>Weakness or abnormal rigidity of leg</b> yes <input type="checkbox"/> no <input type="checkbox"/> / left leg <input type="checkbox"/> right leg <input type="checkbox"/>		
<b>Extent of weakness or abnormal rigidity of arm</b> <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe		<b>Extent of weakness or abnormal rigidity of leg</b> <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe		
<b>Weakness or abnormal rigidity of trunk</b> yes <input type="checkbox"/> no <input type="checkbox"/>		<b>Weakness or abnormal rigidity of head / neck</b> yes <input type="checkbox"/> no <input type="checkbox"/>		
<b>Extent of weakness or abnormal rigidity of trunk</b> <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe		<b>Extent of weakness or abnormal rigidity of head / neck</b> <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe		
<b>Perception &amp; Speech</b> <i>(please tick accordingly)</i>				
	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				
<b>Activities of daily living</b> <i>(please tick accordingly)</i>				
<b>eating &amp; drinking</b> essential aids: <input type="checkbox"/> tube in stomach <input type="checkbox"/> gastric tube		independent		
		Independent with special tools		
		nutrition must be prepared & assistance is needed		
		completely dependent		
<b>Nutritional requirements</b>		<input type="checkbox"/> Diabetes I <input type="checkbox"/> other metabolic diseases:		
		<input type="checkbox"/> Allergies & <input type="checkbox"/> intolerances: <input type="checkbox"/> milk/lactose I <input type="checkbox"/> wheat/gluten I <input type="checkbox"/> peanuts I <input type="checkbox"/> nuts I <input type="checkbox"/> eggs I <input type="checkbox"/> others:		
		<input type="checkbox"/> vegetarian I <input type="checkbox"/> vegan <input type="checkbox"/> no meat I <input type="checkbox"/> no pork I <input type="checkbox"/> no fish		

<b>Personal hygiene (bathing, grooming)</b>	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: ____		
<b>Dressing</b>	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: ____		
<b>Mobility</b>	independent		
	with aids independently possible (e.g. walking stick, orthoses, rollator, wheelchair)		
	requires assistance for walking		
	can NOT move independently (e.g. wheelchair)		
	Is bedridden and a care giver is needed for repositioning		
<b>Required aids</b> <input type="checkbox"/> no aids	glasses, contact lenses		
	walking stick / cane		
	rollator / walker		
	orthoses, for:		
	wheelchair		
	others:		
<b>Bladder and toilet use</b>	completely continent		
	occasional incontinence, independent cleaning & change of pants/sanitary napkins: <input type="checkbox"/> urine / <input type="checkbox"/> stool		
	often incontinent, needs support to clean & change pants / sanitary napkins: <input type="checkbox"/> urine / <input type="checkbox"/> stool		
	completely incontinent required aids: <input type="checkbox"/> permanent catheter / <input type="checkbox"/> pants / <input type="checkbox"/> urinal condom		
<b>Support through care givers</b> <i>(please tick accordingly)</i>			
no <input type="checkbox"/>	yes <input type="checkbox"/> At what times?	Care giver on call <input type="checkbox"/> At what times?	1:1 support <input type="checkbox"/> At what times?
Care giver:	<input type="checkbox"/> only female	<input type="checkbox"/> only male	<input type="checkbox"/> does not matter
<b>Objectives of the patient</b>			