cereneo
CENTER FOR NEUROLOGY & REHABILITATION

Patient questionaire 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 *(please tick accordingly)*

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	

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 leg** yes ☐ no ☐ / left leg ☐ right leg ☐
Extent of weakness or abnormal rigidity of arm ☐ mild ☐ moderate ☐ severe	**Extent of weakness or abnormal rigidity of leg** ☐ 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
Nutritional requirements	☐	☐ Diabetes I ☐ other metabolic diseases:
		☐ Allergies & ☐ intolerances: ☐ milk/lactose I ☐ wheat/gluten I ☐ peanuts I ☐ nuts I ☐ eggs I ☐ others:
		☐ vegetarian I ☐ vegan ☐ no meat I ☐ no pork I ☐ no fish

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