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Exit Therapy Questionnaire Review

Name of Patient: _____ Chart # _____
Date of Birth: _____ / _____ / _____ Exam Date: _____
Name of person completing this section:_____

Please let us know if there have been any changes with patient's demographic information since starting the therapy program: (☐please check if no changes)

_____
_____

1) List all initial goals that have been achieved.

_____
_____
_____

2) List any areas of continuing concern.

_____
_____

3) Please use the following scale to rate each symptom: None Mild Moderate Severe
0 1 2 3 4 5 6

__ Headache	__ Dizziness	__ Sleeping more than usual	__Attention difficulty	__ Motion sensitivity
__ Nausea	__ Lightheadedness	__ Sleeping less than usual	__ Feeling slowed down	__ Ruminating thoughts
__ Vomiting	__ Balance problems	__ Drowsiness	__ Sadness/hopelessness	__ Difficulty in Math
__ Sensitivity to light	__ Numbness/tingling	__ Difficulty concentrating	__ Nervous/anxious	__ Difficulty reading
__ Sensitivity to noise	__ Fatigue	__ Feeling mentally foggy	__ Irritability	__ Symptoms worse
__ Visual Problems	__ Trouble falling asleep	__ Difficulty remembering	__ More emotional	at end of day

4) Please list any changes in your general health since your last visit.

_____
_____

5) Please list all current medications and dosages (☐please check if no changes)

_____
_____

6) Have there been any illnesses /injuries, operations or hospitalizations since your last visit. ☐ Yes ☐ No (If yes, please list details.)

_____
_____

7) Would you be willing to serve as a reference for prospective therapy patients? Yes No

_____ _____
Signature (please circle: patient/spouse/caretaker) Date

_____ _____
Dr. Mackowsky Signature Date