Mercy

Mercy Integrative Medicine and Therapy Services

Patient Questionnaire

Please answer the following questions ***as the patient:***

	YES	NO
Do you have **DIFFICULTY WALKING** or need a wheelchair?	☐	☐
Is a fall or walking/balance problem the reason for your visit today?	☐	☐
Do you regularly use assistive devices (canes,walker,crutches, wheelchair)?	☐	☐
Is **NUTRITION** a long-term medical issue you would like to discuss today?	☐	☐
Have you had a unintended weight loss of 6-8 pounds or more per month?	☐	☐
Have you eaten less than 50% of your normal intake for a period of one week?	☐	☐
Do you need **COMMUNICATION** assistance?	☐	☐
Do you have difficulty hearing and **need assistance from our staff?**	☐	☐
Are you deaf and **need a sign language interpreter?**	☐	☐
Do you have difficulty seeing or reading, and **need assistance from our staff?**	☐	☐
Do you need a **foreign language interpreter?**	☐	☐
Are there religious, traditional or cultural practices that should be in your care?	☐	☐
Do you have difficulty with **UNDERSTANDING** explanations?	☐	☐
Do you have difficulty understanding verbal directions or explanations?	☐	☐
Do you have difficulty understanding written directions or explanations?	☐	☐
Are you concerned about **ABUSE**, neglect, or personal safety?	☐	☐
Are you involved in a hurtful relationship right now (physical, emotional, etc)?	☐	☐
Do you feel safe at home?	☐	☐
Do you have any concerns about **DEPRESSION/SUICIDE?**	☐	☐
Do you have thoughts about trying to harm or kill yourself?	☐	☐
Do you currently have a specific plan for harming yourself?	☐	☐
• What is your plan? _____		