Form Approved OMB No. 0920-1011 Exp. Date 01/31/2020

**Patient Screening Questionnaire** 

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

	Patient ID								
Answe	rs are being provided on behalf of:								
	□ Self								
	□ Child								
Please	answer the questions to the best of your ability. It is ok to say you don't know.								
1.	Our records show that you (your child) was diagnosed with RMSF in(mm/yyyy). Is this correct?  Yes / No / Don't know								
	If no, please provide us with the approximate date in which you (your child) had RMSF:(mm/yyyy)								
2.	Our records also show that you (your child) left the hospital on(MM/DD/YYY). Is this correct?								
	Yes / No / Don't know								
3.	After you left the hospital, where did you (your child) go?  □ Home □ Another hospital								
	□ Nursing home □ Rehabilitation facility								
	□ Other								
	□ Don't remember								
	Name of facility:								
	How long were you there?								
4.	On a scale of 1 to 5 how would you rate your (your child's) overall ability to function <u>before</u> your RMSF illness? (Unable to function in my daily life) $1 - 2 - 3 - 4 - 5$ (perfectly able to function)								
5.	Do you feel like you (your child) has recovered fully from your RMSF illness?  Yes / No / Don't know If yes:								
	how long did it take to get back to normal?								
	If no:								
	have your (your child's) symptoms improved over time?								
	Yes / No / Don't know what symptoms are you (your child) still experiencing?								
	If don't know, proceed to next question.								
6.	On a scale of 1 to 5 how would you rate your (your child's) overall ability to function <u>since</u> your (their) RMSF								
	illness?								

(Unable to function in my daily life) 1 - 2 - 3 - 4 - 5 (perfectly able to function)

7.	dement	tia, Parl /	kinson's	Disease	_	n neurologic w	illness sir	nce your	(their) RI	MSF illne	ess (such a	s a stroke,
		what v	vas the i	Ilness?								
		when	was it di	agnose	d?							
8.	do at th Yes	nis time	?		you (your c	·	do befor	e your RI	MSF illne	ss that y	ou (they)	are unable to
If yes:  please list which activities:												
		do you	ı think th	nis chan	ge is due to	your (their)	RMSF illn	ess?				

Patient ID \_\_\_\_ - \_\_\_