Form Approved
OMB No. 0920-1011
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Patient Screening Questionnaire

Patient ID ____ ____ - ____

Answers 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 before 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 since your (their) RMSF illness?
   (Unable to function in my daily life) 1 — 2 — 3 —4 — 5 (perfectly able to function)

7. Have you (your child) been diagnosed with neurologic illness since your (their) RMSF illness (such as a stroke, dementia, Parkinson's Disease, etc.)

   Yes / No / Don't know

   --If yes:

   what was the illness? _____

   when was it diagnosed?_____

8. Are there any activities which you (your child) used to do before your RMSF illness that you (they) are unable to do at this time?

   Yes / No / Don't know

   --If yes:

   please list which activities:

   _____
   _____

   do you think this change is due to your (their) RMSF illness?

   Yes / No / Don't know