Rebound Physical Therapy Initial Evaluation Questionnaire

Name: _____ Age: _____

What date (approximately) did your symptoms start? _____

How did it happen (gradually, suddenly, injury)? _____

Type of surgery and date (if applicable): _____

My symptoms are currently (please circle): *Getting better* *About the same* *Getting worse*

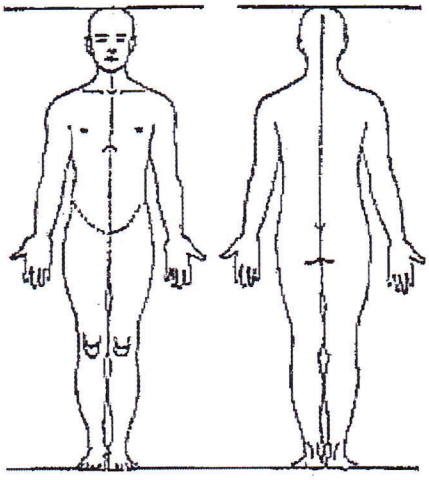
My symptoms currently (please circle): *Come and go* *Are constant*

What makes your symptoms worse (*example: bending, sitting, turning, lifting, standing, walking*)?

_____

Using the following body chart,
Please mark the areas where you
feel symptoms:

≈ Burning
/// Sharp
++ Dull/Achy
-- Throbbing
↓ Shooting
··· Numbness/Tingling



On the scales below, please circle the number which best represents the severity of your symptoms within the past 24 hours?

At worst:	*No pain*	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Worst pain imaginable*
Current:	*No pain*	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Worst pain imaginable*
At best:	*No pain*	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Worst pain imaginable*

What makes your symptoms better (*example: rest, ice, medication, walking, lying down*)?

_____

Medical History

Occupation: _____

Hobbies and activities (*example: sports, recreational activities, crafts, volunteering*): _____

_____

Past medical history: please circle each condition that you have been told you have or had

Alzheimer's	*Fibromyalgia*	*Osteoarthrits*	*Liver Disease*
Cardiovascular Disease	*High Blood Pressure*	*Parkinsons*	*Lung Disease*
Stroke	*History of Cancer*	*Rheumatoid Arthritis*	*Allergies/Asthma*
Current Infection	*Weak Immune System*	*Traumatic Brain Injury*	*Depression*
Diabetes	*Lupus*	*Kidney Disease*	*None*

Other symptoms: please circle all that apply:

Fever/chills/sweats	*Poor balance (falls)*	*Unexplained weight loss*	*Changes in appetite*
Difficulty swallowing	*Shortness of Breath*	*Dizziness*	*abdominal Pain*
Headaches	*Changes in bowel*	*Changes in bladder function*	*Nausea/vomiting*
Increased pain at night	*Changes in vision*	*Changes in hearing*	*Fainting*

Diagnostic Testing/Imaging: _____

Smoker: Yes No Are your currently pregnant or think you might be Pregnant? Yes No

Do you have a pacemaker? Yes No Any allergies? _____

Is there anything else you would like to include that could potentially interfere with treatment?

_____

Past Surgical History (list all and date): Please list all current medications below or provide list:

_____ _____

_____ _____

_____ _____

What would you like to accomplish with physical therapy? _____

Patient Signature: _____ Date: _____