REBOUND PHYSICAL THERAPY MEDICAL HISTORY

Occupation: ____

Hobbies and activities (example: sports, recreational activities, crafting, volunteer work):

____

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

Alzheimer's	Fibromyalgia	Osteoarthritis	Liver Disease
Cardiovascular Disease	High Blood Pressure	Parkinson's	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	Weight loss	Changes in appetite
Difficulty swallowing	Shortness of breath	Dizziness	Abdominal pain
Headaches	Changes in bowel	Changes in bladder	Nausea/vomiting
Increased pain at night	Changes in vision	Changes in hearing	Fainting

Have you had any diagnostic testing or imaging done recently? ☐ Yes ☐ No

If yes, where? ____

Smoker: ☐ Yes ☐ No Are you currently pregnant or think that you may be pregnant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No Any allergies? ______________________

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

____

Past Surgical History: (list all and date):

____

____

Please list all current medication below or provide us with a list:

____

____

What would you like to accomplish with physical therapy? ______________________

Patient Signature: ______________________________ Date: ____________