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 of surgery (if applicable)? _____

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

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

_____

Use the following body chart to please mark the areas where you feel the symptoms:

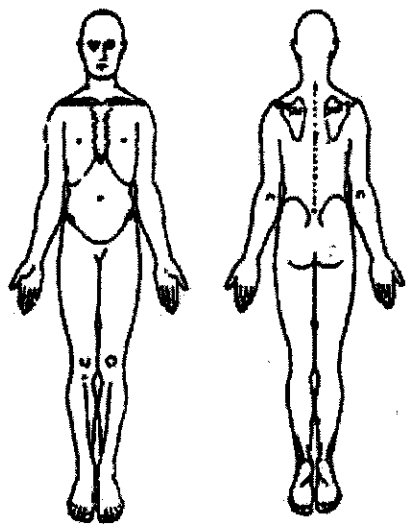
≈ Burning

/// Sharp

++ Dull/Achy

-- Throbbing

... Numbness/Tingling



On the scales below, please circle the number which best represents the severity of your symptoms within the past 24 hours: 0 represents no pain and 10 represents the worst pain.

At worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

What tends to make your symptoms better (example: rest, ice, medication, walking, lying down)?

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