Rebound REHABILITATION PHYSICAL THERAPY

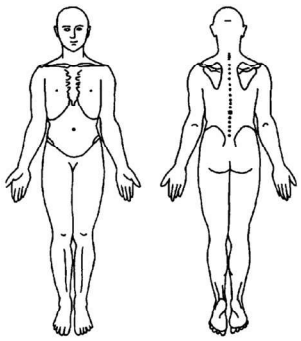
Patient Follow-up Questionnaire

Patient Name _____Date: _____

Please take your time to accurately complete. Detail will help your therapist with the evaluation.

I. Pain

1. Please mark picture where you have pain or other symptoms →
2. Please describe your pain: (CHECK THAT APPLY)
   - □ Localized □ Radiating
   - □ Constant □ Frequent □ Intermittent
   - □ Sharp □ Dull/Achy □ Burning □ Electrical □ Throbbing
   - □ Deep □ Superficial
   - □Other:_____
3. Rate your current pain perception on the following scale: 0 = No Pain



Pain at REST ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain with ACTIVITY ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

II. Symptoms

What is the status of your symptoms since you began your rehabilitation?

☐ Better: ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ Other:_____

☐ Worse If so, please explain? _____

☐ No effect if so, please explain? _____

☐ OTHER: _____

At present, how do your symptoms respond?

Worse when: (circle all that apply) Bending, Sitting/Rising, Standing, Walking, Lying,

Kneeling, Overhead Activities, Dressing, Other: _____

Better when: (circle all that apply) Bending, Sitting/Rising, Standing, Walking, Lying,

Kneeling, Overhead Activities, Dressing, Other: _____

Are you currently undergoing other treatments/interventions for this condition? Yes/No

☐ Occupational Therapy ☐ Chiropractic ☐ Massage ☐ Acupuncture

☐ Physician Interventions: _____

III. Patient Goals

Do you feel your goals from PT are being addressed? Yes/No If No, please explain: _____

_____

Do you have any new goals? _____

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