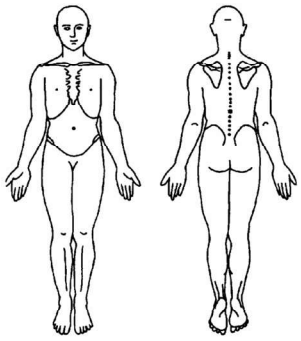
Rebound REHABILITATION PHYSICAL THERAPY

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 pain perception on the following scale: 0 = No Pain

(Lowest)	1	2	3	4	5	6	7	8	9	10	(Highest)
	□	□	□	□	□	□	□	□	□	□	

II. Symptoms

1. Date of injury/onset of symptoms _____
2. Cause of injury: ❑ Car Accident ❑ Work-related ❑ Sport ❑ None ❑ Other: _____
3. Symptoms at onset: _____
   _____
4. Symptoms now: ❑ Same ❑ Better ❑ Worse _____
   _____

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:

_____

Previous treatment: ❑ Physical Therapy ❑ Chiropractic ❑ Massage ❑ Acupuncture
❑ Other: _____

Result of Treatment: _____

Current Functional status (%)

100% ---- 90% ---- 80% ---- 70% ----- 60% ---- 50% ----- 40% ----- 30% ----- 20% ----- 10% -----0%

_____ _____

Patient Signature Date

Medical Treatment Form

Past/Current Medical History

❑ No significant past medical history

❑ Arrhythmia
❑ Asthma
❑ Cancer
❑ Congestive Heart Failure
❑ COPD
❑ Coronary Artery Disease
❑ Depression
❑ Weaken Immune System
❑ Diabetes
❑ Fractures
❑ Heart Attack
❑ Dates: _____
❑ History of falls
❑ Hypertension
❑ MS
❑ Others: _____
❑ Mitral Valve Prolapse
❑ Osteoporosis
❑ Pacemaker
❑ Currently Pregnant
❑ PVD (Vascular Disease)
❑ Rheumatoid Arthritis
❑ Stroke

History of: ❑ Smoking ❑ Alcohol ❑ Substance Abuse ❑ Other: _____
Family History of Current Condition: ❑ No ❑ Yes, Explain: _____
Other Significant Family History: ❑ None ❑ Cancer ❑ Heart Condition ❑ Other: _____
If yes, please explain: _____

Past/current surgical History:

❑ No history of surgery

❑ Ankle surgery L / R
❑ Elbow surgery L / R
❑ Hand surgery L / R
❑ Knee arthroscopy L / R
❑ Total hip replacement L / R
❑ Total knee replacement L / R
❑ Total shoulder replacement L / R
❑ Rotator cuff repair L / R
❑ Bypass
❑ Cancer
❑ Pacemaker
❑ Spine: _____

Medication:

❑ No Medication taken
❑ See provided list
❑ Steroids (i.e. prednisone)

❑ Anti-depressant
❑ Anti-anxiety
❑ Blood thinner
❑ Other:_____
❑ Hypertension
❑ Diabetes
❑ Heart Medication
❑ Pain Killer
❑ Anti-inflammatory
❑ Osteoporosis

Allergies:

❑ None/unknown
❑ Latex
❑ Other: _____

Patient Name: _____ **Signature:** _____ **Date:** _____