REBOUND PHYSICAL THERAPY

NAME_____DATE_____

Why did you come to Rebound Physical Therapy (what are your symptoms?) _____
_____

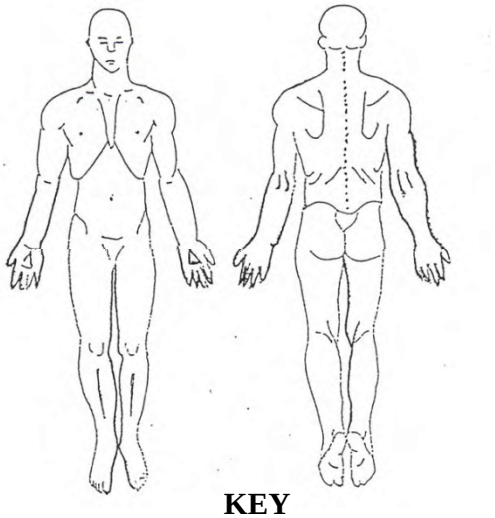
Date of onset: _____

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible _____

Do you have or have you had any of the following:

	Yes	No
Diabetes	❒	❒
Osteoarthritis	❒	❒
Osteoporosis	❒	❒
Pacemaker	❒	❒
Headaches	❒	❒
Cancer	❒	❒
Ringing in your ears	❒	❒
Rheumatic Arthritis	❒	❒
Hypoglycemia	❒	❒
High Blood Pressure	❒	❒
Heart Disease	❒	❒
Dizziness/Fainting	❒	❒
Surgeries	❒	❒
Bowel/Bladder Abnormality	❒	❒
Urine Leakage	❒	❒

Please indicate below where your symptoms are located:



KEY
Numbness =======
Pins and Needles 00000000
Burning Pain XXXXX
Stabbing Pain / / / / / / / / /

If you answered YES to any of the items above, please briefly explain and give the date.

_____
_____

Do you have any allergies? Y N If yes, please list_____

Have you had 2 or more falls or a fall resulting in injury in the past 12 months? Y N

Are you presently taking any medication/supplements (prescription or over the counter)? Y N
If yes, please list medications:

Medication Name: **Dosage/Frequency** **Route (ie: oral, cream)**

_____
_____
_____
_____

What activities do you participate in and would like to return to/continue after therapy?

❒ Aerobics/Yoga ❒ Bicycling ❒ Cardio Machines ❒ Cross Country Skiing ❒ Dancing
❒ Downhill Skiing ❒ Gardening ❒ Golf ❒ Hiking ❒ Running ❒ Swimming ❒ Tennis
❒ Walking ❒ Weight Training ❒ Youth/HS sports ❒ Other_____

What would you like to accomplish with therapy (what are your goals)?_____