REBOUND PHYSICAL THERAPY

Hillsdale Location: 5220 SW 17th Street | Topeka, KS 66604
South Location: 2117 SW 37th Street | Topeka, KS 66611
Phone 785-271-5533 | Fax 785-271-8818

Name:_____Today's Date:_____
Physician:_____DOB:_____
Age:_____
What are we seeing you for today?_____
Specific date of injury/onset of symptoms: (mm/dd/yy)_____
How did it occur?_____
List any previous treatments for this episode:_____
Notes:_____
_____

Past medical history: (please check)

High Blood Pressure	___Yes ___No	Osteoporosis	___Yes ___No
Heart Problems	___Yes ___No	Blood Clots	___Yes ___No
Neurologic Disorders	___Yes ___No	Diabetes	___Yes ___No
Pacemaker	___Yes ___No	Cancer	___Yes ___No
Are you pregnant?	___Yes ___No ___Unsure	Seizures	___Yes ___No
Other: _____		Osteoarthritis	___Yes ___No

Surgery (list type)_____

Any recent health changes (i.e., significant weight gain/loss; bowel/bladder problems; fever; dizziness; changes in vision and/or speech, etc.)?_____

Are you taking any medications? (please list)_____
_____

Allergies to tape/medications? (list)_____

Have you had any of the following tests for this specific incident?___CT scan ___MRI ___X-ray
___EMG ___Bone scan

1. Do you have difficulty sleeping? ___Yes ___No Why?_____
What position do you sleep?_____How many pillows do you use?_____

2. Have you had physical therapy for this problem before? ___Yes ___No When?_____

3. Are you currently being treated by another healthcare provider?___Yes ___No Who?_____

4. What was your level of activity prior to your injury? (circle one) High Moderate Low

5. Are you currently working? ___full time ___light duty ___off ___homemaker ___N/A

6. What is your occupation?_____

7. What does it require?

___lifting	___push/pull	___write	___sitting
___walking	___computer/typing	___twist	___reach
___standing	___kneel/crouch	___carry	___climbing
___repetitive movements		___other:_____	

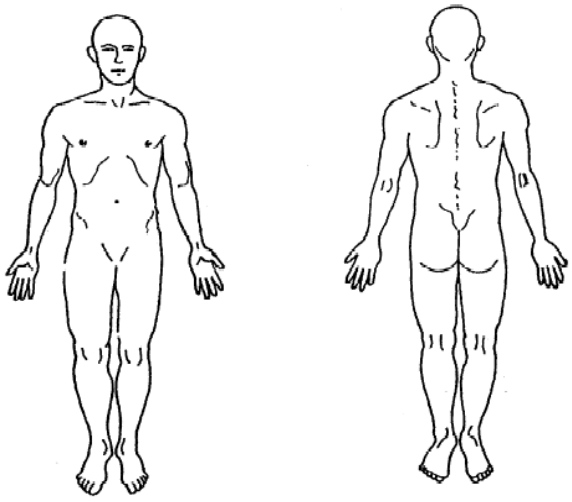
8. When is your next doctor's appt?_____With Whom?_____

(over)

9. Do you have difficulty with the following tasks?

	YES	NO
Getting in / out of bed	___	___
Dressing / Grooming	___	___
Housework	___	___
Laundry	___	___
Bending / Stooping	___	___
Lifting / Carrying	___	___
Standing 30 minutes	___	___
Walking	___	___
Climbing stairs / Curbs	___	___
Grocery shopping / Errands	___	___
Driving	___	___
Recreational activity or Sport	___	___
Other:_____	___	___

10. Describe your pain and mark areas of pain with an "X" and areas of numbness/tingling with "O".



My pain is: ___aching ___burning ___stabbing ___pins and needles
___dull ___sharp ___other:_____

Rank your pain on a scale of 0-10.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild		Moderate		Severe		Intensely severe			Emergency Room

11. Is your pain worse in the Morning / Afternoon / Evening? (circle one)

12. Is your pain constant / come and go? (circle one)

13. What makes your pain worse?_____

14. What eases your pain?_____

Whom may we thank for referring you to Rebound?_____

_____	_____	_____	_____
Patient Signature	Date	Reviewed by therapist	Date