REBOUND HAWAII
Physical Therapy & Massage Therapy

MEDICAL QUESTIONNAIRE

Last Name: _____ First Name: _____ Middle Initial: _____

Age: ____ Height: ____ Weight: ____Occupation: _____Currently Working: __YES __NO

Who may we thank for referring you to Rebound Hawaii? _____

Describe what brings you to physical therapy? _____

Is this a work related injury? __Yes __No

Date of Injury:_____ Type of Surgery and Date of Surgery: _____

Describe how injury occurred: _____

The following have been completed: __ Xray __ MRI __ Other:_____ Results of tests: _____

Describe your pain/symptoms: _____

Do you experience any numbness/tingling: __Yes __ No If YES, describe where and when: _____

Are you having difficulty sleeping due to your pain/symptoms? __Yes __No

Do you experience SEVERE pain at night? __Yes __No

Does time of day affect your symptoms?__Yes __No

Does coughing/sneezing increase your symptoms?__ Yes __No

What makes your symptoms BETTER? _____

What makes your symptoms WORSE? _____

What activities/exercises were you doing before your symptoms appeared, and how frequently?

_____

I am having difficulty with: *(Check all that apply)*

__Moving around in bed	__Getting around my home	__Walking in the community
__Caring for myself/others	__Reaching over head/behind my back	__Completing work duties
__Going up/down stairs	__Completing house chores	__Recreational activity

__Other: _____

MEDICAL QUESTIONNAIRE (continued)

My medical history includes: *(Check all that apply)*

__Asthma	__Bruising easily	__Bowel/Bladder problems	__Cancer/tumors
__Coronary artery disease	__Diabetes	__Dizziness/Fainting	__Epilepsy/Seizures
__Excessive weight loss	__Frequent falls	__Headaches/Migraines	__Hearing problems
__Heart trouble/angina	__High blood pressure	__Osteoporosis	__Poor circulation
__Rheumatoid Arthritis	__Shortness of breath	__Smoking/Tobacco use	

__Other:_____

List surgeries and dates: _____

Do you have a pacemaker, Nitroglycerin patch or implant for pain? _____

List medications/supplements you are currently taking: _____

Have you had any steroid(cortisone) shots to address symptoms? _____

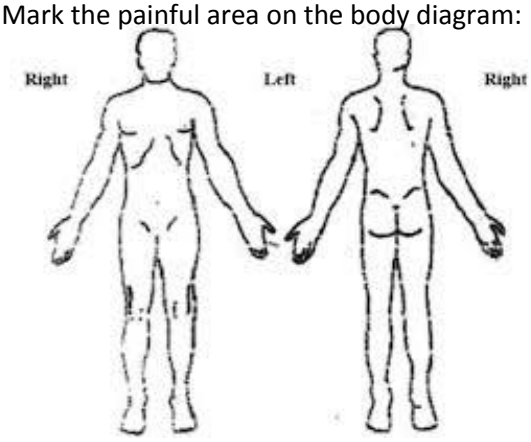
Please rate your pain with the scale below:

Average pain ____

Pain at its WORST ____

Pain at its BEST ____

Mark the painful area on the body diagram:



AUTHORIZATION FOR TREAMENT

I authorize the physical therapists of Rebound Hawaii, LLC to administer such treatment which is therapeutically necessary on the basis of findings during the course of treatment. The information provided is accurate to be best of my knowledge.

Print name_____ Signed_____Date_____

If patient is a minor:

Parent/Guardian name_____ Signed _____

Rev. 04/2015