



## 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)*

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Bruising easily     | <input type="checkbox"/> Bowel/Bladder problems | <input type="checkbox"/> Cancer/tumors     |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Dizziness/Fainting     | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Excessive weight loss   | <input type="checkbox"/> Frequent falls      | <input type="checkbox"/> Headaches/Migraines    | <input type="checkbox"/> Hearing problems  |
| <input type="checkbox"/> Heart trouble/angina    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Poor circulation  |
| <input type="checkbox"/> Rheumatoid Arthritis    | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> 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: \_\_\_\_\_

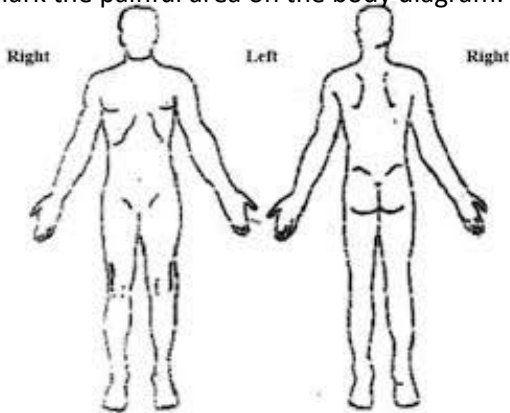
Have you had any steroid(cortisone) shots to address symptoms? \_\_\_\_\_

Please rate your pain with the scale below:

Wong-Baker FACES™ Pain Rating Scale



Mark the painful area on the body diagram:



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## AUTHORIZATION FOR TREATMENT

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 \_\_\_\_\_

\*\* \_\_\_\_\_ Initial here if you would like to receive emails from Rebound Hawaii with health tips and coupons exclusively for our patients.