

# Medical History/ Evaluation



Name: \_\_\_\_\_

Date: \_\_\_\_\_

Is an Attorney involved in this case? Yes No

Have you had any other Diagnostic or Rehabilitative Services for this injury/episode? Yes No  
 If so, what type? (i.e., X-Rays, MRI, EMG, other) \_\_\_\_\_ When? \_\_\_\_\_

Have you had surgery for this injury? Yes No Number of Surgery(ies) \_\_\_\_\_

Type of Surgery: \_\_\_\_\_ Date(s) of Surgery(ies) \_\_\_\_\_

Are you currently taking any prescription or non-prescription medications? Yes No

Anti- Inflammatories \_\_\_\_\_ List Other Medications: \_\_\_\_\_

Muscle Relaxers \_\_\_\_\_

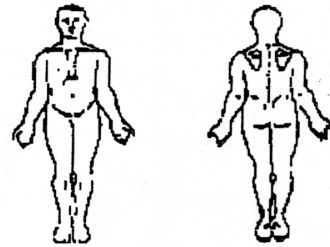
Pain Medication \_\_\_\_\_

How has pain changed since onset? \_\_\_\_\_

Do you now have or have you ever had any of the following?

	Yes	No
Asthma, Bronchitis, or Emphysema		
Shortness of Breath/Chest Pain		
Coronary Heart Disease or Angina		
Do you have a pacemaker?		
High Blood Pressure		
Heart Attack/ Surgery		
Stroke/ TIA		
Blood Clot/ Emboli		
Epilepsy/ Seizures		
Thyroid Trouble/ Goiter		
Anemia		
Infectious Disease		
Diabetes		
Cancer or Chemotherapy/ Radiation		
Arthritis/ Swollen Joints		
Osteoporosis		
Gout		
Sleeping Problems/ Difficulties		
Emotional/ Psychological problems		
Bowel or Bladder Problems		
Do you smoke? _____	How Much? _____	
Severe or Frequent Headaches		
Vision or Hearing Difficulties		
Numbness or Tingling		
Dizziness or Faintness		
List any other information that would assist us in your care: _____		

Indicate on the diagram where the pain is:



	Yes	No
Weakness		
If so, where: _____		
Weight Loss/Energy Loss		
If so, where: _____		
Hernia		
Varicose Veins		
Allergies		
Any Pins or Metal Implants		
Joint Replacements		
Neck Injury/Surgery		
Shoulder Injury/Surgery		
Elbow Injury/Surgery		
Back Injury/Surgery		
Knee Injury/Surgery		
Leg/Ankle/Foot Injury/Surgery		
Are you pregnant?		
Alcohol Consumption? _____		
How Much? _____		

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize the release of payment directly to Rebound Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_