Medical History/ Evaluation

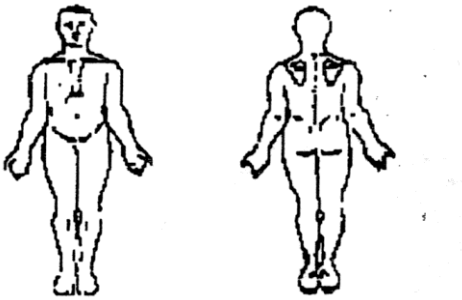
Name: _____ Date of Birth_____
Date: _____ Referring Physician_____

Is your injury a result of an auto accident or a work related incident? □Yes □No
Have you had any other Diagnostic or Rehabilitative Services related to 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) _____
How has pain changed since onset? _____

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

Asthma, Bronchitis, or Emphysema	Yes	No
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:



Weakness (area):	Yes	No
Weight Loss/Energy Loss	□	□
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? _____		

REQUIRED FOR MEDICARE PATIENTS):
Height _____feet _____inches Weight _____
Have you fallen in the past year? □Yes □No (If yes, please list number of falls: ___)
Are you currently taking any prescription or non-prescription medications? □Yes □No
→ If 'Yes' please attach a list of current medications or list on the back.

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 an additional $25 collections cost incurred. 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:_____