Rehab in Motion...
REBOUND
Physical, Occupational & Hand Therapies

Bellingham 360-752-1575
Lynden 360-354-5245
Reboundot.com

Health History Form

Patient Name ___________________________________

Please fill out the following questionnaire as completely as possible. Your input is very important. This enables your therapist to design an appropriate and safe treatment plan for you.

Case History

Date of onset____________ Due to___________________

Briefly describe your problem______________________

____

____

Recent symptom trend ◯ Better ◯ Worse ◯ Same

Diagnostic Imaging (check all that apply)

◯ X-ray ◯ MRI ◯ CT Scan ◯ EMG/NCVS

Results if known___________________________________

Surgery ◯ Yes ◯ No Date_____________________

Surgery performed_______________________________

Occupation____

Current status ◯ Full time ◯ Part time ◯ Retired

◯ Normal duty ◯ Light duty

Pain Behavior

Pain Frequency ◯ Constant ◯ Intermittent (daily)

◯ Occasional (< daily) ◯ Sporadic (< weekly)

Pain rating on a scale from 0 to 10
(0 = no pain, 10 = worse pain you can imagine)

What is the worst your pain gets? 0 1 2 3 4 5 6 7 8 9 10

What is the best your pain gets? 0 1 2 3 4 5 6 7 8 9 10

What is your pain currently? 0 1 2 3 4 5 6 7 8 9 10

Does time of day affect your symptoms? ◯ Yes ◯ No

What activities make you worse? ___________________

____

Has any recent treatment been helpful? _____________

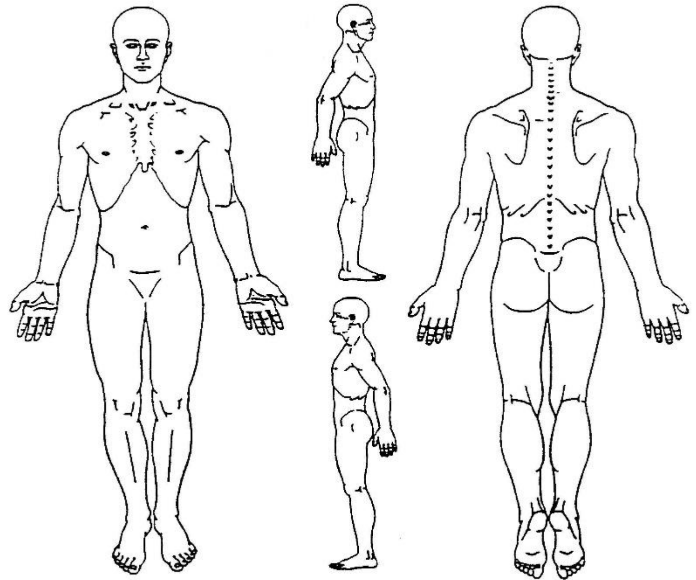
____

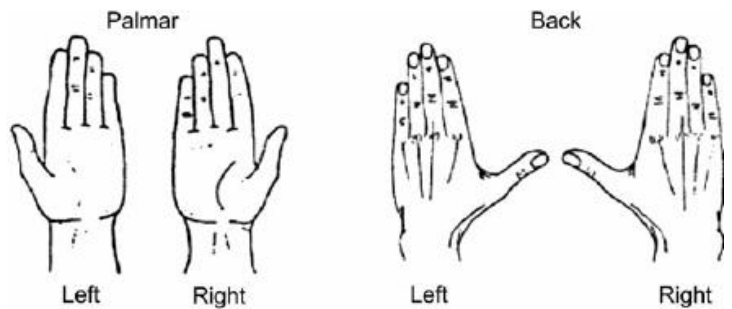
Have you had therapy in the past for this problem?

____

Body Diagram

Shade areas of pain, use XXXs to indicate areas of numbness, tingling or burning.





Other History

Previous injuries or surgeries relevant to your problem?

____

____

____

What are your goals for therapy?

____

____

Health History Form Part 2

Medical History

I currently have, OR have a history of: (check all that apply)

☐ Heart disease ☐ High blood pressure ☐ Cancer ☐ Epilepsy / seizures
☐ Diabetes ☐ Thyroid problems ☐ Stroke ☐ Arthritis
☐ Depression / anxiety ☐ Osteoporosis ☐ Fibromyalgia ☐ COPD / asthma
☐ Dizziness / falls ☐ Bowel / bladder problems ☐ Migraines ☐ Poor circulation
☐ Hepatitis ☐ Auto-immune disorder

Comment:____

Do you smoke or use tobacco products? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Are you pregnant or may be pregnant? ☐ Yes ☐ No

In the last 3 months have you experienced any major changes in your health? ☐ Yes ☐ No

Medications & Allergies

Medication Name	Reason for Medication

Any known drug allergies or material allergies (such as latex)?

- ____
- ____

Authorization for Treatment

I authorize the therapists of ReBound PT, OT & Hand Therapy to administer such treatment as is prescribed and considered therapeutically necessary during the course of treatment. The information provided is accurate to the best of my knowledge.

Signature ____ Date ___________________________