CONSULT / INJURY CONSULT
PATIENT CONTACT INFO & RELEASE

Sports & Physical Therapy

Date: _____

PERSONAL INFORMATION

Legal Name _____ Preferred Name _____
First Middle Initial Last

Address _____

City _____ State _____ Zip _____

☐ Male ☐ Female Age _____ Date of Birth _____ SSN _____

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Appointment Reminders ☐ Email ☐ Text ☐ Voice If text or voice, which number? _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Spouse Name _____ Phone Number _____

☐ Minor - Parent(s) Name(s) _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Emergency Contact Relationship to Patient _____

COACH / TRAINER INFORMATION

Coach/Trainer Name _____ Phone Number _____

MEDICAL HISTORY

Date of Injury _____ Primary Care Physician _____

FINANCIAL / RELEASE INFORMATION

Charges, if applicable, for this treatment and any supplies dispensed are due and payable at the time of treatment unless prior arrangements have been made.

Medical Release: I authorize Rebound Sports & Physical Therapy to release information from my file to my coaches, trainers, employer, or doctors as needed.

I certify that I have reviewed and understand the above information supplied by me and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures, patient care, and therapy supplies, which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Rebound Sports & Physical Therapy.

Patient/Guardian Signature _____ **Date** _____

CONTINUED ON BACK

PATIENT HEALTH QUESTIONNAIRE

rebound
Sports & Physical Therapy

CURRENT SYMPTOMS

1. Describe your symptoms_____
   a. When did your symptoms start?_____
   b. How did your symptoms begin?_____
   c. What activities produce your symptoms/make them worse?_____

2. What describes the nature of your symptoms?
   ○ Sharp ○ Shooting ○ Dull Ache ○ Burning ○ Numb ○ Tingling

3. How are your symptoms changing?
   ○ Getting Better ○ Not Changing ○ Getting Worse

4. During the past 4 weeks:

	NONE									WORST
a. Indicate the worst intensity of your symptoms:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**
b. At best, what is the intensity of your symptoms:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**

5. Who have you seen for your symptoms? ○ No One ○ Medical Doctor ○ Chiropractor ○ Physical Therapist ○ Other

6. What is your occupation? _____

MEDICATIONS/ALLERGIES

If you are currently taking any medications please list below:

Medication	
1	
2	
3	
4	

Are you allergic to any medications? YES/ NO
if YES, what? _____

Any other known allergies? YES / NO
if YES, what? _____

Please provide details of any recent/relevant surgeries below:

Surgery / Procedure	Date