Rapid Rehabilitation PC
Patients' choice for caring and personalized service

Initial Evaluation
Medical History

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Next Doctor's Appointment:_____

Onset/ Injury Date: _____

Surgery Performed for condition and date:

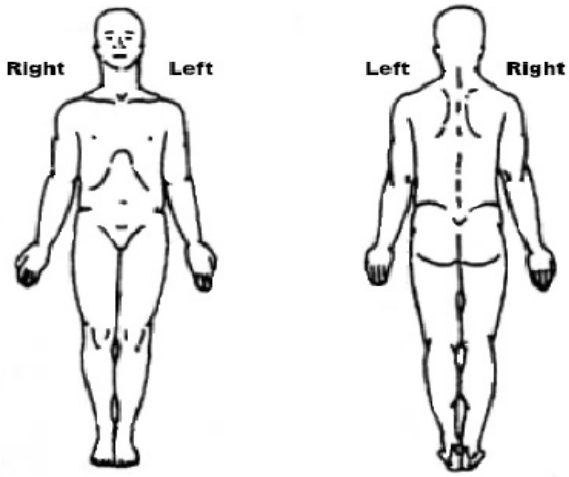
_____

Previous hospitalization for this condition: ____ Yes ____ No
Admit date: _____ Discharge Date: _____

Chief Complaint / Reason for Visit: _____

_____

Hand Dominance: ____ Right ____ Left



Where are you experiencing pain, please mark the diagram.

Check each that applies to the specific area

	Please write the Specific Body part (Example: knee, wrist)	Burning	Sharp	Dull or Achy	Throbbing	Shooting	Numbness/ Tingling	Other (please write in the type of pain)	Is your Pain Constant or Intermittent (Please write C or I)	If the pain is Intermittent, What % of time is the pain present?
Neck		☐	☐	☐	☐	☐	☐			
Upper Extremity		☐	☐	☐	☐	☐	☐			
Lower Extremity		☐	☐	☐	☐	☐	☐			
Trunk		☐	☐	☐	☐	☐	☐			
Low back/SI		☐	☐	☐	☐	☐	☐			

Current pain rating (0=none/ 10=severe): 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ◉ severe

In the past 3 days, please write a number 0-10): least pain _____ max pain _____

What relieves your symptoms? _____

What worsens your symptoms? _____

Describe previous treatment for this condition and whether it helped or worsened symptoms:

_____

_____

Patient Name: _____ **Date:** _____

History of Home Health Care: ☐ No ☐ Yes; If so when and have you been discharged?

_____

History of Falls? ☐ No ☐ Yes; If so when and briefly describe what happened?

_____

Do you now or have you ever had any of the following (check all that Apply)?

☐ Alzheimer's
☐ Cardiovascular Disease
☐ Cauda Equina Syndrome
☐ Cerebral Vascular Accident
☐ Current Infection
☐ Diabetes Mellitus Type 1
☐ Diabetes Mellitus Type 2
☐ Fibromyalgia
☐ Fracture or Suspected Fracture
☐ High Blood Pressure
☐ History of Cancer
☐ Huntington's
☐ Immunosuppression
☐ Lupus
☐ Muscular Dystrophy
☐ Obesity
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Parkinson's
☐ Traumatic Brain Injury

Diagnostic Testing/ Imaging for your condition (check all that apply; If so, put date and location of the image):

☐ CT Scan: Date_____ Imaging Location _____
☐ MRI: Date _____ Imaging Location _____
☐ X-ray: Date _____ Imaging Location _____

Are you currently taking any prescription or Non- prescription Medications (Please List Below)? If you have provided a list please check here: ☐

List any other information that would assist us in your care

_____

Based upon your awareness, what are your expectations/ goals while in this program?

_____

Is there anything else you would like to include or ask your therapist?

_____

_____

_____ _____

Patient or Personal Representative Signature **Date**