Back-in-Action
REHABILITATION, S.C.

Please answer the questions to the best of your ability based on how you feel today. It may be necessary to observe certain precautions during your treatment if any of the following medical conditions exist. Thank you for your cooperation.

Patient Name: Date of Birth: Date of Visit:

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

☐ High blood pressure ☐ Cancer ☐ Currently pregnant ☐ Dizziness

☐ Pacemaker ☐ Diabetes ☐ Heart condition ☐ Stroke

☐ Metal implants ☐ Loss of sensation ☐ Circulation problems

☐ History of seizures ☐ Drug allergies Please list: _____

_____

☐ Infectious diseases such as tuberculosis, hepatitis A,B or C, HIV, etc.

Please list: _____

_____

Do you smoke? ☐ Yes ☐ No

What is the condition that brought you to therapy? _____

_____

Have you ever been treated before for this condition? _____

_____

What is your goal for therapy? _____

List dosage and frequency of medications including over-the-counter, herbals, vitamins/mineral/dietary or nutritional supplements you are currently taking: _____

_____

List any surgeries you have had _____

_____

_____

Please indicate your range of pain by circling the number when it is at its lowest level and when it is at its highest level.
(0=least pain; 10=most pain)

0 1 2 3 4 5 6 7 8 9 10

Circle the words that best describe your pain:

Constant frequent occasional aching stabbing burning throbbing shooting

What makes your pain worse?_____

What makes your pain better?_____

Patient Signature: _____

Therapist Signature: _____