PHYSICAL THERAPY · APPLIED NEUROSCIENCE · HUMAN PERFORMANCE

01 Patient Information

Please complete this confidential medical history before your initial appointment.

A. Personal Information

Legal first name

Legal last name

Preferred name (optional)

Date of birth (MM/DD/YYYY)

Mobile phone

Email address

B. Care Team & Background

Primary care physician

Referring clinician (if any)

Occupation / usual work

1. What is the primary reason for visiting Rehab2Fitness?

- ○ Pain / injury recovery
- ○ Movement or balance
- ○ Neurological symptoms
- ○ Athletic performance
- ○ Combination of the above

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How did you hear about Rehab2Fitness?

02 Injury & Current Concern

Your symptoms, injury history, limitations, and what a successful experience would look like.

A. Primary Concern

1. What is the main reason you're seeking treatment?

2. Are there any other symptoms, injuries, or concerns you'd like addressed?

3. When did your current problem begin?

4. How did your symptoms begin?

- ○ Suddenly, following an injury or specific event
- ○ Gradually over time
- ○ Following surgery or a medical procedure
- ○ Recurring problem that has returned
- ○ Unsure

5. Describe what happened when your symptoms first began.

6. How have your symptoms changed since they began?

- ○ Gradually improving
- ○ Gradually worsening
- ○ Staying about the same
- ○ Fluctuating between better and worse

B. Symptom Description

7. Where are you experiencing symptoms?

Include body regions and right/left side.

8. What symptoms are you experiencing? Select all that apply.

- ☐ Pain or aching
- ☐ Weakness
- ☐ Tingling
- ☐ Instability
- ☐ Limited mobility
- ☐ Loss of coordination
- ☐ Stiffness
- ☐ Numbness
- ☐ Burning sensation
- ☐ Swelling
- ☐ Muscle tightness
- ☐ Other

9. Do your symptoms travel or spread to other areas?

- ○ Yes
- ○ No
- ○ Unsure

If yes, describe where.

10. Rate your pain or symptom intensity (0-10).

0 = no symptoms; 10 = worst imaginable.

Current intensity (0-10)

At best in past week (0-10)

At worst in past week (0-10)

11. How frequently do your symptoms occur?

- ○ Constantly throughout the day
- ○ Come and go
- ○ Only during specific movements or activities
- ○ Unpredictable

12. When do your symptoms tend to be most noticeable?

- ☐ Upon waking
- ☐ During the day
- ☐ In the evening
- ☐ During the night
- ☐ During activity
- ☐ After activity
- ☐ With prolonged inactivity
- ☐ No consistent pattern

C. Aggravating & Relieving Factors

13. What movements, activities, or positions make your symptoms worse?

14. What helps reduce your symptoms?

15. How long does it typically take for your symptoms to settle after being aggravated?

- Immediately or within minutes
- 15-60 minutes
- Several hours
- A day or longer
- Varies considerably

D. Functional Limitations

16. Which activities are currently affected?

- Walking
- Sitting
- Bending
- Driving
- Work activities
- Golf or other sports
- Daily self-care
- Standing
- Stairs
- Lifting / carrying
- Sleeping
- Exercise / fitness
- Balance
- Other

17. What specific activities can you no longer do, or can only do with difficulty?

18. Have you changed or reduced your exercise, training, or recreational activities because of this problem?

- ○ Yes
- ○ No

If yes, describe what has changed.

19. How has your condition affected your sleep?

- ○ No significant impact
- ○ Difficulty falling asleep
- ○ Waking during the night
- ○ Difficulty finding a comfortable position
- ○ Several of the above

E. Previous Episodes, Injuries, Scars & Dental History

20. Have you experienced this same problem before?

- ○ Yes
- ○ No

If yes, when did it occur, and how was it resolved?

21. Have you had any other significant injuries, fractures, accidents, or surgeries, even if they seem unrelated to your current concern?

○ Yes ○ No

If yes, list each event, the body region involved, approximate date, and any lasting effects.

22. Do you have any scars or surgical incision sites from previous injuries or procedures?

○ Yes ○ No

If yes, note the location, approximate date, and any sensitivity, numbness, tightness, or discomfort.

23. Have you had any major dental work or jaw-related procedures?

○ Yes ○ No

Examples: tooth extractions, root canals, implants, orthodontic work, jaw surgery, or significant bite changes. Include approximate dates and any ongoing issues.

F. Your Perspective

24. What concerns you most about your current condition?

25. What is the most important thing you would like me to understand about your condition?

G. Goals & Expectations

26. What are your primary goals for treatment?

What would you most like to improve, restore, or achieve?

27. What activities would you like to return to, or perform at a higher level?

28. What would a successful experience at Rehab2Fitness look like for you?

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Imagine you've completed your care and are very happy with the results. What has changed in your life, health, or performance?

29. What are your top priorities? Select up to three.

- ☐ Pain reduction
- ☐ Strength and stability
- ☐ Athletic performance
- ☐ Injury prevention
- ☐ Understanding my condition
- ☐ Improved mobility
- ☐ Balance and coordination
- ☐ Confidence in movement
- ☐ Energy and endurance
- ☐ Long-term health and resilience

03 Physical Activity & Athletic Performance

Your activity level, physical capacity, and performance.

A. Current Physical Activity

1. What types of physical activity or exercise do you participate in regularly?

- ☐ Walking / hiking
- ☐ Cardiovascular exercise
- ☐ Tennis / pickleball
- ☐ Yoga / Pilates
- ☐ Cycling
- ☐ Currently inactive
- ☐ Strength training
- ☐ Golf
- ☐ Running
- ☐ Swimming
- ☐ Other

2. How frequently do you exercise or participate in physical activity?

- ○ Daily
- ○ 4-6 days per week

- ○ 2-3 days per week
- ○ Once per week
- ○ Rarely or currently unable

3. Describe your typical exercise or training routine.

Types of exercise, duration, intensity, and weekly routine.

4. How would you describe your current physical fitness compared with one year ago?

- ○ Much better
- ○ Somewhat better
- ○ About the same
- ○ Somewhat worse
- ○ Much worse

If your fitness has changed, what do you think contributed?

B. Physical Performance

5. Are you experiencing limitations in any of the following areas?

- ☐ Strength
- ☐ Speed
- ☐ Flexibility / mobility
- ☐ Coordination
- ☐ Movement confidence
- ☐ None of the above
- ☐ Power / explosiveness
- ☐ Endurance
- ☐ Balance
- ☐ Reaction speed
- ☐ Recovery after exercise

6. When do you notice the greatest decline in your physical performance?

- ☐ At the beginning of activity
- ☐ During high-intensity efforts
- ☐ Under pressure or stress
- ☐ No noticeable decline
- ☐ As I become fatigued
- ☐ During complex movements
- ☐ Following prolonged inactivity
- ☐ Other

7. Have you noticed changes in your physical performance that cannot be fully explained by pain or injury?

- ○ Yes
- ○ No
- ○ Unsure

If yes, please describe.

8. Are there particular movements or activities in which you feel less coordinated, stable, powerful, or confident than you used to?

C. Additional Performance Information

9. Do you participate in sports or other athletic activities for which performance is important to you?

Please specify the sport, frequency, and any performance limitations.

10. Is there anything else about your physical abilities, training, or athletic performance that would be helpful to know before your assessment?

04 Previous Care & Treatment History

Your previous treatment experiences and outcomes.

A. Previous Healthcare Providers

1. Have you previously received treatment for your current condition?

Yes

No

2. Have you consulted any healthcare or wellness practitioners regarding this condition?

If yes, please list the practitioners you've seen.

3. Have you been given a specific diagnosis or explanation for your condition?

Include what you were told about your condition.

B. Previous Treatments & Testing

4. What treatments or interventions have you tried?

Describe previous therapies, exercises, procedures, medications, or other treatments.

5. Have you undergone any diagnostic imaging or testing related to your current problem?

- ☐ X-ray
- ☐ CT scan
- ☐ EMG / nerve conduction
- ☐ None
- ☐ MRI
- ☐ Ultrasound
- ☐ Other testing

Relevant findings, if known

C. Treatment Response

6. Which treatments have provided the most meaningful improvement?

What helped, and how much improvement did you experience?

7. Were these improvements lasting or temporary?

- ○ Mostly lasting
- ○ Mostly temporary
- ○ A combination of both
- ○ No significant improvement

8. What treatments were ineffective or made your symptoms worse?

9. Are you currently receiving treatment or following an exercise program for this condition?

Describe your current treatment, exercises, or medications related to this concern.

05 Comprehensive Medical History

Your overall health and medical background.

A. Current & Previous Medical Conditions

1. Have you ever been diagnosed with or treated for any of the following conditions?

Select all that apply, including conditions that are controlled or no longer causing symptoms.

CARDIOVASCULAR & CIRCULATORY

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart disease / coronary artery disease
- ☐ Heart attack or heart failure
- ☐ Irregular heartbeat / arrhythmia
- ☐ Stroke or transient ischemic attack (TIA)
- ☐ Blood clots / DVT / pulmonary embolism
- ☐ Poor circulation / vascular disease

METABOLIC & ENDOCRINE

- ☐ Type 1 or Type 2 diabetes
- ☐ Prediabetes / blood sugar regulation problems
- ☐ Thyroid disorder
- ☐ Hormonal or endocrine disorder
- ☐ Osteoporosis / osteopenia

RESPIRATORY & IMMUNE

- ☐ Asthma
- ☐ Sleep apnea
- ☐ Chronic inflammatory condition
- ☐ COPD / chronic lung disease
- ☐ Autoimmune disorder
- ☐ Frequent or recurrent infections

MUSCULOSKELETAL & OTHER MEDICAL CONDITIONS

- ☐ Arthritis / degenerative joint disease
- ☐ Spinal disc or degenerative spine condition
- ☐ Kidney or liver disease
- ☐ Anemia or blood disorder
- ☐ Anxiety or depression
- ☐ Rheumatoid or inflammatory arthritis
- ☐ Cancer (current or previous)
- ☐ Digestive or gastrointestinal disorder
- ☐ Chronic fatigue or fibromyalgia
- ☐ Other medical condition

Details about any conditions selected - diagnosis, approximate year, current status, and relevant treatment

B. Surgical & Hospitalization History

2. Have you ever undergone surgery?

- ○ Yes
- ○ No

If yes, list procedures, body regions, and approximate dates.

3. Have you been hospitalized for a significant illness, injury, or medical emergency?

- ○ Yes
- ○ No

If yes, explain the reason and approximate date.

4. Do you have any implanted medical devices or joint replacements?

- ☐ Pacemaker / defibrillator
- ☐ Joint replacement
- ☐ Spinal hardware
- ☐ Other implanted device
- ☐ None

If applicable, provide details.

C. Medications, Supplements & Allergies

5. Please list all current prescription and over-the-counter medications.

Medication, dosage (if known), and reason for taking it.

6. Do you regularly take vitamins, nutritional supplements, or other wellness products?

List supplements and approximate dosages, or enter None.

7. Do you have any known allergies or sensitivities to the following?

- ☐ Latex
- ☐ Adhesives / tape

Describe your reaction, if applicable.

D. General Health & Medical Considerations

8. How would you describe your overall health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

9. Have you experienced any recent unexplained changes in your health?

- ☐ Unexplained weight loss or gain
- ☐ Fever / night sweats
- ☐ Unusual shortness of breath
- ☐ Other
- ☐ Persistent fatigue
- ☐ Unexplained swelling
- ☐ Changes in bowel or bladder function
- ☐ None

If applicable, explain symptoms and when they began.

10. Have you had any recent infections, significant illnesses, or changes in your medical condition?

11. Is there any other aspect of your medical history that you believe may be relevant to your care?

06 Neurological & Sensory Health

Vision, balance, sensation, coordination, cognitive function, concussion, and jaw health.

> Your nervous system influences movement, balance, coordination, and physical performance. Changes in these areas may contribute to the problems you're seeking treatment for, even when they seem unrelated.

A. Vision & Visual Function

1. Do you experience any of the following visual symptoms?

- ☐ Blurred vision
- ☐ Eye strain or fatigue
- ☐ Difficulty tracking moving objects
- ☐ Difficulty judging depth or distance
- ☐ Headaches during visual tasks
- ☐ Double vision
- ☐ Difficulty focusing
- ☐ Light sensitivity
- ☐ Discomfort in visually busy environments
- ☐ None of the above

2. Do you notice symptoms when moving your eyes or turning your head?

○ Yes ○ No ○ Unsure

If yes, please describe.

3. Do you experience difficulty with reading, prolonged computer work, driving, or visually demanding activities?

B. Vestibular Function & Balance

4. Do you experience any of the following?

- ☐ Dizziness
- ☐ Motion sickness
- ☐ Difficulty walking in the dark
- ☐ Disorientation with movement
- ☐ None of the above
- ☐ Spinning sensation (vertigo)
- ☐ Unsteadiness when walking
- ☐ Feeling off-balance
- ☐ Fear of falling

5. What activities or positions tend to bring on dizziness or imbalance?

- ☐ Turning the head
- ☐ Looking down
- ☐ Standing up
- ☐ Busy environments
- ☐ Exercise or sports
- ☐ Looking up
- ☐ Rolling over in bed
- ☐ Walking on uneven ground
- ☐ Riding in a car
- ☐ No consistent pattern

6. Have you experienced any falls or near-falls during the past 12 months?

- ○ Yes
- ○ No

If yes, how often and under what circumstances?

7. Have you noticed changes in hearing or any of the following symptoms?

- [ ] Reduced hearing
- [ ] Ear fullness or pressure
- [ ] None of the above
- [ ] Ringing in the ears (tinnitus)
- [ ] Sound sensitivity

C. Sensation & Body Awareness

8. Do you experience any of the following sensory changes?

- [ ] Numbness
- [ ] Burning sensations
- [ ] Increased sensitivity to touch
- [ ] Difficulty sensing body position
- [ ] Tingling
- [ ] Reduced sensitivity to touch
- [ ] Unusual temperature sensations
- [ ] None of the above

Where do these symptoms occur? Include the body region and right / left / both sides.

9. Do you ever feel that a particular part of your body is difficult to control, activate, coordinate, or sense accurately?

- ○ Yes
- ○ No
- ○ Unsure

If yes, describe the body region and activity.

10. Do you notice significant differences between the right and left sides of your body in strength, stability, sensation, or coordination?

D. Coordination & Movement Control

11. Have you noticed any of the following changes in your movement?

- ☐ Clumsiness or reduced coordination
- ☐ Difficulty with precise movements
- ☐ Reduced reaction speed
- ☐ Changes in walking pattern
- ☐ None of the above
- ☐ Tremors or shaking
- ☐ Difficulty with quick movements
- ☐ Difficulty with walking or turning
- ☐ Movement becoming less controlled with fatigue

12. Do you experience difficulty coordinating movements during exercise, sports, or daily activities?

13. Have you noticed any changes in speech, swallowing, facial movement, or tongue control?

- ○ Yes
- ○ No

If yes, describe and indicate when the changes began.

E. Cognitive Function & Brain Endurance

14. Have you noticed difficulty with any of the following?

- ☐ Concentration or sustained attention
- ☐ Mental processing speed
- ☐ Multitasking
- ☐ Mental fatigue
- ☐ None of the above
- ☐ Memory or forgetfulness
- ☐ Decision-making
- ☐ Reaction time
- ☐ Feeling mentally overwhelmed

15. Do you find it more difficult to perform physical activities while concentrating, talking, or completing another mental task?

- ○ Frequently
- ○ Sometimes
- ○ Rarely
- ○ Never
- ○ Not sure

16. Do you experience mental fatigue that affects your concentration, coordination, or physical performance?

F. Concussion & Head Injury History

17. Have you ever experienced a concussion or significant head injury, whether diagnosed or suspected?

○ Yes ○ No ○ Unsure

> If you answered Yes or Unsure, complete questions 18 and 19. Otherwise, skip to question 20.

How many, and when was the most recent? Include approximate dates and circumstances.

18. Following your head injury, did you experience any new or worsening problems in these areas?

Select all that apply, including symptoms that have since resolved.

SLEEP

- ☐ Difficulty falling or staying asleep
- ☐ Sleeping more or less than usual
- ☐ Waking unrefreshed

EMOTIONAL STABILITY

- ☐ Increased irritability or frustration
- ☐ Anxiety or heightened stress
- ☐ Mood changes or emotional sensitivity
- ☐ Depressed mood

PHYSICAL SYMPTOMS

- ☐ Headaches
- ☐ Dizziness or balance difficulties
- ☐ Neck pain
- ☐ Visual disturbances or light sensitivity
- ☐ Fatigue or decreased exercise tolerance
- ☐ Reduced coordination

COGNITIVE FUNCTION

- ☐ Difficulty concentrating
- ☐ Memory changes
- ☐ Slower processing speed
- ☐ Difficulty multitasking
- ☐ Mental fatigue
- ☐ Decision-making difficulties
- ☐ No noticeable changes

19. Have these problems resolved or changed since the injury?

- ○ Completely resolved
- ○ Improved, but some remain
- ○ Mostly unchanged
- ○ Worsened
- ○ Symptoms fluctuate
- ○ No symptoms occurred

Describe any problems that remain.

G. Recent Changes & Current Symptoms

20. Have you noticed any significant changes in your neurological, sensory, or cognitive function over the past 6-12 months?

○ Yes ○ No ○ Unsure

If yes, what changed, when did it begin, and has it improved or worsened?

21. Are you currently experiencing any of the following problems?

- ☐ Changes in vision
- ☐ Dizziness or balance problems
- ☐ Weakness or movement difficulties
- ☐ Speech or swallowing difficulties
- ☐ Slower reaction time
- ☐ Sleep difficulties
- ☐ Hearing difficulties
- ☐ Reduced coordination
- ☐ Numbness or sensory changes
- ☐ Memory or concentration difficulties
- ☐ Emotional or mood changes
- ☐ None of the above

Additional details, if applicable

Sudden new weakness, facial drooping, speech difficulty, or other stroke-like symptoms require emergency medical attention.

H. Jaw & Temporomandibular Joint (TMJ)

22. Have you noticed any recent changes in your jaw movement, bite, or jaw-related symptoms?

○ Yes ○ No ○ Unsure

If yes, describe the changes and when they began.

23. Do you experience any of the following jaw-related problems?

- ☐ Jaw pain or discomfort
- ☐ Jaw locking or catching
- ☐ Difficulty opening the mouth fully
- ☐ Pain while chewing
- ☐ Ear pain or pressure
- ☐ None of the above
- ☐ Clicking or popping
- ☐ Clenching or teeth grinding
- ☐ Jaw stiffness or tightness
- ☐ Headaches near the temples
- ☐ Changes in how the teeth fit together

I. Additional Information

24. Is there anything else about your neurological function, vision, balance, sensation, coordination, or jaw function that you would like me to know?

07 Lifestyle, Sleep & Recovery

Your daily habits, stress, and recovery.

A. Sleep Quality & Habits

1. How many hours do you typically sleep per night?

- ○ Less than 5 hours
- ○ 5-6 hours
- ○ 6-7 hours
- ○ 7-8 hours
- ○ More than 8 hours

2. How would you describe your overall sleep quality?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

3. Do you experience any of the following sleep difficulties?

- ☐ Difficulty falling asleep
- ☐ Waking earlier than intended
- ☐ Daytime sleepiness
- ☐ None of the above
- ☐ Waking during the night
- ☐ Feeling unrefreshed upon waking
- ☐ Irregular sleep schedule

Please provide any additional details about your sleep, including patterns, challenges, or recent changes.

B. Stress & Stress Management

4. How would you describe your typical daily stress level?

- ○ Low
- ○ Mild
- ○ Moderate
- ○ High
- ○ Very high

Are there particular factors contributing to your stress?

5. Do you feel you have effective strategies for managing stress?

- ○ Yes
- ○ Somewhat
- ○ No

If yes, what strategies do you use?

How effective have these strategies been for you?

- ○ Very effective
- ○ Moderately effective
- ○ Slightly effective
- ○ Not effective
- ○ Not applicable

Please explain, if you would like.

C. Recovery Habits

6. Which activities or habits do you regularly use to support recovery?

- ☐ Walking or light exercise
- ☐ Meditation / relaxation
- ☐ Massage / bodywork
- ☐ Cold exposure
- ☐ Other
- ☐ Stretching / mobility
- ☐ Breathing exercises
- ☐ Sauna / heat therapy
- ☐ Rest / recovery days

Describe any other recovery strategies you use and how helpful they have been.

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7. Is there anything about your lifestyle, sleep, stress, or recovery that you believe may be contributing to your current condition?