Physical Rehabilitation Questionnaire

Name of Owner: 
Address: 
Phone: 
Email: 

Patient Name: 
Species/Breed: 
Sex: 
Age: 
Weight: 

Best time and way to reach you: ______________________________________________________

Referring/Regular Veterinarian if different then Everhart: _________________________________

Please help us prove your pet with a complete evaluation by taking the time to fill out this questionnaire carefully. If there is anything you wish to bring to my attention, which is not on this form, please note it in the comments section.

**Presenting Complaint:**
What is the main problem you would like to help your pet with? ____________________________
________________________________________________________________________________
________________________________________________________________________________

Hong long ago did this problem begin (be as specific as possible)? __________________________
________________________________________________________________________________

To what extent does this problem interfere with your pet’s daily activities? _________________
________________________________________________________________________________

What diagnosis have you been given for this problem? What kind of treatment have you tried?  
________________________________________________________________________________
________________________________________________________________________________

List current medications/herbal/supplements your pet is on including heartworm/flea prevention: 
________________________________________________________________________________
________________________________________________________________________________
Current Status:
Name your pet’s diet (type of food, how much give, how often, any treats): ______________________
________________________________________________________________________________

Please detail your pet’s current activity level (length of walks, frequency of walks, duration of playtime):
________________________________________________________________________________
________________________________________________________________________________

Medical History:
Past Significant Illness: ________________________________________________________________
________________________________________________________________________________

Surgeries: _______________________________________________________________________
________________________________________________________________________________

Significant Trauma: ________________________________________________________________
________________________________________________________________________________

Allergies: ________________________________________________________________
________________________________________________________________________________

Any negative reactions to medications/vaccines (please give specifics): ______________________
________________________________________________________________________________
________________________________________________________________________________

Neurological/Behavior Problems:

☐ Seizures  ☐ Loss of Balance  ☐ Lack of Coordination  ☐ Behavior Changes
☐ Anxiety Bad  ☐ Temper  ☐ Good Attitude Easily susceptible to stress
☐ Weakness  ☐ Muscle weakness  ☐ Difficulty getting up

Any other neurological or behavioral problems? _____________________________________________
________________________________________________________________________________
________________________________________________________________________________

Musculoskeletal:

☐ Likes being massaged  ☐ Moves from touch/massage  ☐ Neck pain
☐ Back pain  ☐ Knee pain  ☐ Shoulder pain
☐ Hip pain  ☐ Muscle weakness  ☐ Stiff
☐ Limping  ☐ Difficulty getting up  ☐ Easily susceptible to stress
☐ Keeps tail tucked in

Any other joint, bone or muscle problems? _____________________________________________
________________________________________________________________________________
________________________________________________________________________________

If stiff or experiencing muscle pain, how long has your pet experienced this problem? __________
Is the stiffness or pain worse:  □ Day  □ Night  □ After rest  □ After activity
□ When is it cold out  □ Hot out  □ Damp out

Additional Comments: _____________________________________________________________
_____________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Authorization for Perform Physical Rehabilitation Therapy

I understand that the following are considered alternative forms of therapy:
• Underwater Treadmill
• Neuromuscular Electrical Stimulation
• Laser Therapy
• Therapeutic Ultrasound

In addition, I understand that all medicine, both alternative and conventional, run some inherent risk.

I understand that before my pet enters the underwater treadmill, he or she must urinate and defecate prior to appointment. If my pet urinates or defecates while in the underwater treadmill, I understand I must pay a $20 service fee per incident.

I authorize Dr. Stephanie Menefee to perform physical rehabilitation therapies on my pet. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

Signature: ______________________________ Date: __________________