VITAL PHYSICAL THERAPY
INTEGRATIVE HANDS-ON THERAPY

Patient history

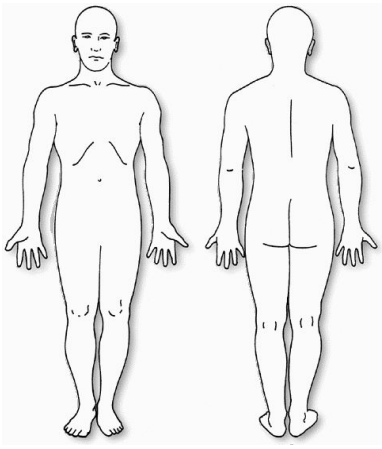
Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information.

Name:			Today's date:						
	First Name	Last Name							
DOB:		Age:		Marital status:	M	S	W	D	
Occupation:		Employer:							

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Stabbing //// Numbness oooo Pins/needles ---- Burning xxxx
Ache ++++



Please rate your pain in the last 24-72 hours **Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.**	At its worst	
	At its best	
	At present	
	Night (sleeping)	

What other types of treatment have you had for this problem?									
	Physical Therapy		Acupuncture		Massage		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)									

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Check the box if you have had any of the following medical conditions?										
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No

Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?				Yes	No
Please Describe:					
In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	How many times do you wake in the night?	
Is your sleep restful?	Yes	No	What bed do you sleep on (firm, soft, memory foam, etc)	
Do you find it difficult to change positions?	Yes	No	What type of pillow do you use?	