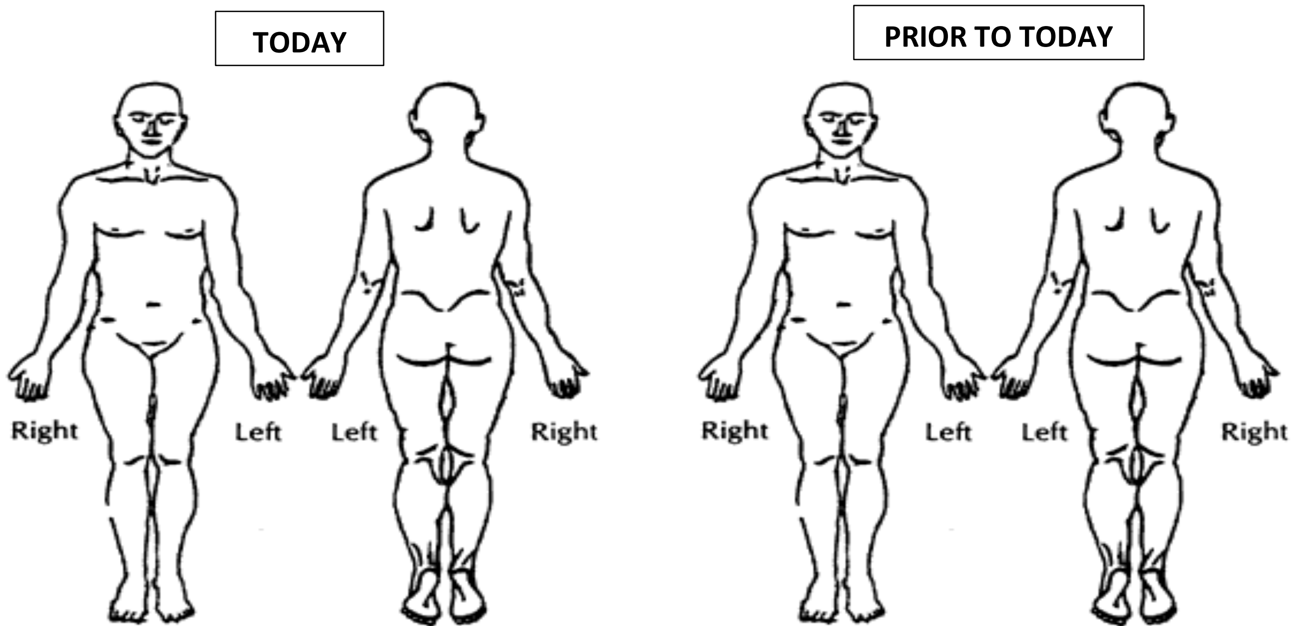
Patient Intake/
Medical History

VASTA PHYSICAL THERAPY Inc.

Name: ______________________________________ Date: _____________ DOB: _____________

The following Chart lets us know how you are feeling.

1. Please use an **O** to indicate location(s) of PAIN.
2. Please use **X** marks to indicate where you feel NUMBNESS or TINGLING.



3. Please Circle your *current* pain levels. Please X your pain levels at *worst* & at *best*

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst pain imaginable

4. What activities, postures or positions INCREASE your pain? ____

____

5. What makes your pain LESS bad? ____

6. Since its initiation, have your symptoms: O Worsened O Improved O Remained About the Same

7. Any other changes in symptoms? ____

8. Have you experienced these symptoms previously? O No O Yes (explain) _________________________

____

9. What do you think *originally* caused your pain? ____

____

10. Is your injury a result of a motor vehicle accident? O No O Yes

11. Have you had any diagnostic tests done for your current injury? (e.g. MRI, X-ray, etc)

    O Yes O No If yes, what test(s)? ____

12. Have you had surgery recommended to you? O No O Yes

13. Have you had any past surgeries? O No O Yes (explain) ___________________________________

    ____

14. Are you taking any medications? ____

15. Are you pregnant? O No O Yes (weeks?) ____________

16. Are you currently under the care of a physician, chiropractor, or other health care provider other than your

    Primary Care Physician? O No O Yes (list) ______________________________________

    ____

17. What is the name of your Primary Care Physician and the name of the clinic? __________________

    ____

18. When was your last physical exam with your Primary Care Physician? _____ /_____ /_____

19. What are your goals for physical therapy? ____

    ____

19. Is there anything else you would like for us to know? ___________________________________

    ____

20. What is the best method for us *to communicate with you*? O Email: __________________________

    (To remind you of upcoming appointments, scheduling future appointments, etc.) O Phone: _______________ O Other:_______________

Patient Signature: ____________________________________ Date: __________

Parent/Guardian Signature: ______________________________ Date: __________
(If Applicable)