**Patient Intake/ Medical History**

# VASTA PHYSICAL THERAPY Inc.

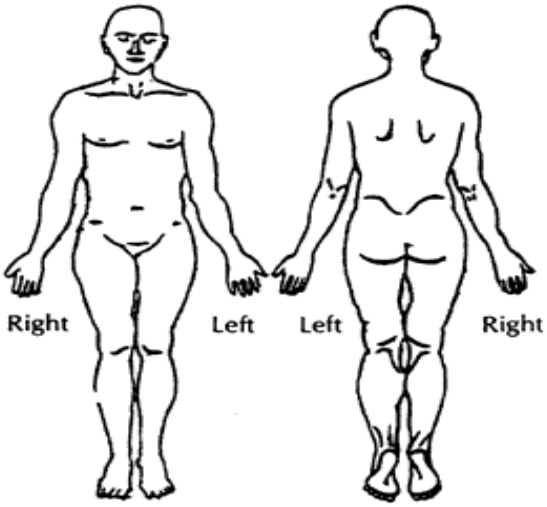
Name: _____ Date: _____ DOB: _____

Preferred pronouns: _____

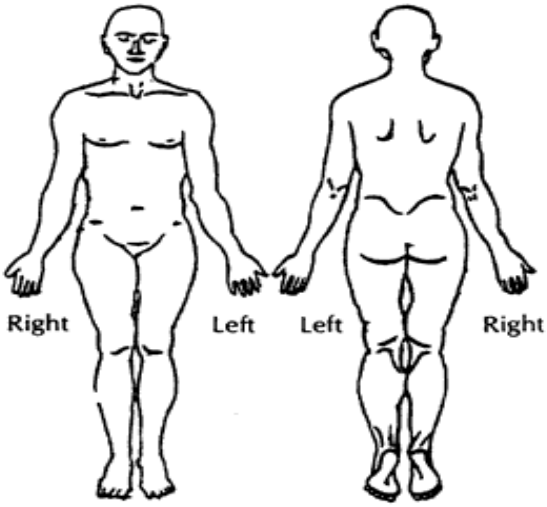
The following Chart lets us know how you are feeling.

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

**TODAY**




**PRIOR TO TODAY**




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. 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)? _____

(OVER)

11. Please list 3-4 activities that you are currently experiencing difficulty with. Be sure to include any "high level" activities that you would ultimately like to return to.

    Under each activity, check the number that best correlates to the current level of difficulty you experience with each activity. *This is *required* for many insurance companies, so please take a moment to complete.

Activity: _____

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Unable to perform — Able to perform activity at same level as before injury

Activity: _____

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Unable to perform — Able to perform activity at same level as before injury

Activity: _____

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Unable to perform — Able to perform activity at same level as before injury

Activity: _____

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Unable to perform — Able to perform activity at same level as before injury

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

13. Have you had surgery recommended to you for this injury? O No O Yes

14. Have you had any past surgeries? O No O Yes (explain) _____

_____

15. Are you taking any medications? O No O Yes (list) _____

_____

16. Are you pregnant? O No O Yes (weeks?) _____

17. 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) _____

18. What is the name of your Primary Care Physician and the name of the clinic? _____

_____

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

20. What are your goals for physical therapy? _____

_____

20. Is there anything else you would like for us to know? _____

22. How did you hear about us? _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If Applicable)