

VASTA PHYSICAL THERAPY Inc.

Name: _____ Date: _____ DOB: _____

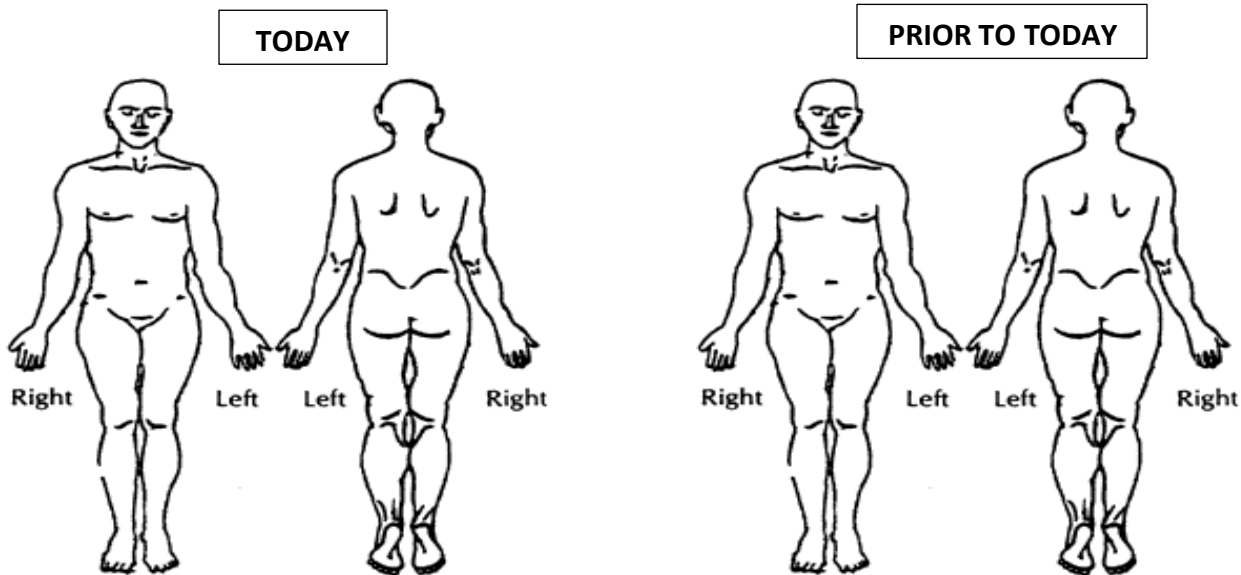
Preferred pronouns: _____

1. What is the CHIEF complaint that brings you here today? _____

The following Chart lets us know how you are feeling.

2. Please use an **O** to indicate location(s) of PAIN.

3. Please use **X** marks to indicate where you feel NUMBNESS or TINGLING.



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

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

5. What activities, postures or positions INCREASE your pain? _____

6. What makes your pain LESS bad? _____

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

8. Any other changes in symptoms? _____

9. Have you experienced these symptoms previously? No Yes (explain) _____

10. What do you think *originally* caused your pain? _____

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

Yes No If yes, what test(s)? _____

12. 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

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

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

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

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

17. Are you pregnant? No Yes (weeks?) _____

18. Are you currently under the care of a physician, chiropractor, or other health care provider other than your Primary Care Physician? No Yes (list) _____

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

20. When was your last physical exam with your Primary Care Physician? ____ / ____ / ____

21. 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)