Vibrance Physical Therapy and Wellness

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Patient Intake Form

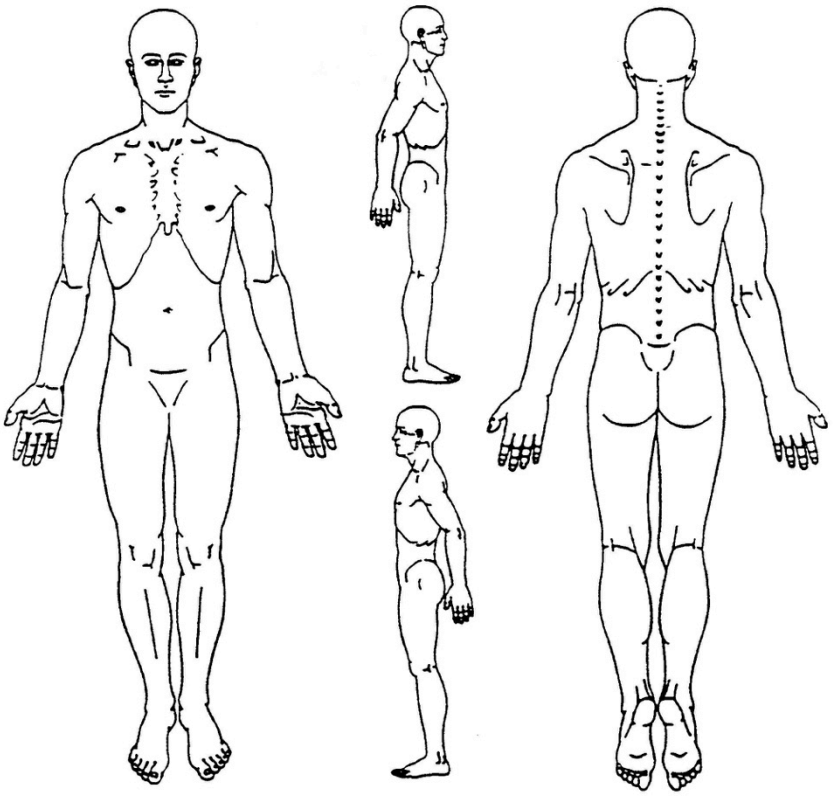
Patient Name: _____ Date: _____

Patient DOB: _____ Claim # (if applicable): _____

Patient Condition

Reason for visit: _____
When did your symptoms appear? _____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:



D = Dull

B = Burning

N = Numb

S = Stabbing

T = Tingling (Pins and Needles)

C = Cramping

How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation?

What activities or movements are painful to perform?
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

According to the scale below, please describe the level of your pain or discomfort:

0 = No Pain Unbearable = 10

Rate the pain you have **right now**: _____ Rate your pain at its **best** in the past week: _____
Rate your **average** pain in the past week: _____ Rate your **worst** pain in the last week: _____

Health History

What treatment have you already received for your condition?
☐ Medication(s) ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services
☐ None ☐ Other

Name(s) of doctor(s) that have treated you for your condition: _____
_____

Date(s) of last: Physical Exam _____ Spinal X-ray _____ Blood Test _____
Spinal Exam _____ Chest X-ray _____ Urine Test _____
Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Alcoholism	□ Yes	□ No	High Cholesterol	□ Yes	□ No
Anemia	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Anorexia	□ Yes	□ No	Liver Disease	□ Yes	□ No
Appendicitis	□ Yes	□ No	Migraines	□ Yes	□ No
Arthritis	□ Yes	□ No	Mononucleosis	□ Yes	□ No
Asthma	□ Yes	□ No	Multiple Sclerosis	□ Yes	□ No
Bleeding Disorder	□ Yes	□ No	Osteoporosis	□ Yes	□ No
Bulimia	□ Yes	□ No	Pacemaker	□ Yes	□ No
Cancer	□ Yes	□ No	Parkinson's Disease	□ Yes	□ No
Chicken Pox	□ Yes	□ No	Pneumonia	□ Yes	□ No
Diabetes	□ Yes	□ No	Polio	□ Yes	□ No
Emphysema	□ Yes	□ No	Prosthesis	□ Yes	□ No
Epilepsy	□ Yes	□ No	Rheumatoid Arthritis	□ Yes	□ No
Fractures	□ Yes	□ No	STD	□ Yes	□ No
Gout	□ Yes	□ No	Stroke	□ Yes	□ No
Heart Disease	□ Yes	□ No	Thyroid Problems	□ Yes	□ No
Hepatitis	□ Yes	□ No	Tumor	□ Yes	□ No
Herniated Disk	□ Yes	□ No	Ulcer	□ Yes	□ No
Herpes	□ Yes	□ No	Other _____	□ Yes	□ No

Describe your exercise: □ None □ Light □ Moderate/Daily □ Heavy/Elite Level
What is your work activity? □ Sitting □ Standing □ Light Labor □ Heavy Labor

Habits:

□ Alcohol Drinks/Week: _____
□ Caffeine Cups/Day: _____
□ Street Drugs
□ Marijuana
□ Prescription Meds
□ High Stress Level
□ Soda Pop
□ Tobacco Packs/Day: _____

Are you pregnant? □ Yes □ No Due date: _____

Past Injuries/Surgeries:	Description:	Date:
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications: _____
_____

Allergies: _____

Supplements (Vitamins/Minerals/Herbs): _____
_____
_____

By my signature below, I certify that the information I have provided above is complete, accurate, and truthful to the best of my knowledge.

Patient Name/Name of Responsible Party: _____

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____