

Vibrance Physical Therapy and Wellness

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Patient Intake Form

Patient Name:	Date:
Patient DOB: Claim # (if appli	cable):
Patient Condition	
Reason for visit:	S □ No □ Unknown
Please draw the location of your pain or discomfort on the represent the type(s) of pain:	ne images below. Use the symbols shown to
How often do you have this pain? Is it constant or does it come and go?	D = Dull B = Burning N = Numb S = Stabbing T = Tingling (Pins and Needles) C = Cramping
Is it constant or does it come and go? Does it interfere with your $\ \square$ Work $\ \square$ Sleep	☐ Daily Routine ☐ Recreation?
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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:												
							1			ı		
0 = No Pain			Unbearable = 10									
Rate the pain you have right now : Rate your pain at its best 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:												
								Spinal Exam		Spinal X-ray Bloo Chest X-ray Urin MRI, CT-Scan, Bone Scan	e Test	
							Place a mark on "Yes" or "No" to indicate if you have had any of the following:					
AIDS/HIV Alcoholism Anemia	□ Yes □ Yes □ Yes	□ No □ No □ No	High Blood Pressure High Cholesterol Kidney Disease	□ Yes □ Yes □ Yes	□ No □ No □ No							
Anorexia Appendicitis	□ Yes □ Yes	□ No □ No	Liver Disease Migraines	□ Yes □ Yes	□ No □ No							
Arthritis Asthma Bleeding Disorde	□ Yes □ Yes r □ Yes	□ No □ No □ No	Mononucleosis Multiple Sclerosis Osteoporosis	□ Yes □ Yes □ Yes	□ No □ No □ No							
Bulimia Cancer Chicken Pox	□ Yes □ Yes □ Yes	□ No□ No□ No	Pacemaker Parkinson's Disease Pneumonia	□ Yes □ Yes □ Yes	□ No □ No □ No							
Diabetes Emphysema	□ Yes □ Yes	□ No □ No	Polio Prosthesis	□ Yes □ Yes	□ No □ No							
Epilepsy Fractures Gout	□ Yes □ Yes □ Yes	□ No □ No □ No	Rheumatoid Arthritis STD Stroke	□ Yes □ Yes □ Yes	□ No □ No □ No							
Heart Disease Hepatitis	□ Yes □ Yes	□ No □ No	Thyroid Problems Tumor	□ Yes □ Yes	□ No □ No							
Herniated Disk Herpes	□ Yes □ Yes	□ No □ No	Ulcer Other	□ Yes □ Yes	□ No □ No							

Describe your exercise : □ None What is your work activity? □ Sitti	□ Light □ Moderate/Daily □ Heavy/Elite Level ng □ Standing □ Light Labor □ Heavy Labor		
Habits: □ Alcohol Drinks/Week: □ Caffeine Cups/Day: □ Street Drugs □ Marijuana			
Are you pregnant? □ Yes □ No	Due date:		
Broken Bones Dislocations Surgering	Description: Date:		
Medications:			
Allergies:			
Supplements (Vitamins/Minerals/Herb	s):		
	ne information I have provided above is complete, accurate,		
Patient Name/Name of Responsible Part	y:		
Signature:	Date:		
Therapist Signature:	Date:		