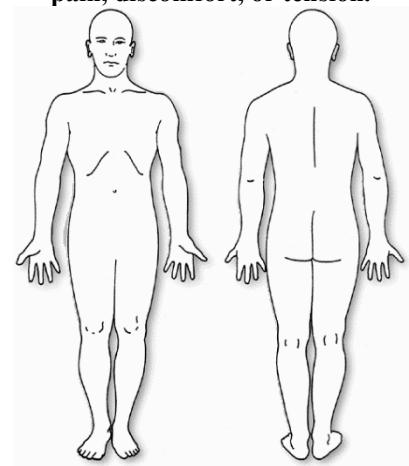


**Welcome to SPINE PT!**  
**Please help me serve you better by taking a few minutes to provide the following information.**

First, Last Name:			Today's date:	
Address:				
City / State / ZIP:			UTAH	
Phone #	Mobile:			Home:
DOB:			Age:	
Email:				
Occupation:			Employer:	
<b>Emergency Contact</b>	Name:			Phone:
<b>Primary Care Physician</b>	Name:			Date of next visit
<b>Specialist Physician</b>	Name:			Date of next visit

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

**The following is very important in the evaluation process.**  
**Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.**

<b>What is the primary issue/problem that brings you in today?</b>	<p>Please shade in areas where you have pain, discomfort, or tension.</p> 
<b>Secondary concern/problem?</b>	
<b>As a result, I am now having difficulty with:</b>	
<b>Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?</b>	
<b>When did your symptom(s) begin? (Date):</b>	

<b>Please rate your pain in the last 24-72 hours</b>  Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.	At its worst	
	At its best	
	At present	
	Night (sleeping)	



At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
<input type="checkbox"/>	Massage	<input type="checkbox"/>	Bodywork	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Myofascial Release	<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Epilepsy / seizures	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Blackouts
<input type="checkbox"/>	Weight change	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Metal implants/ Spinal Fusion	<input type="checkbox"/>	Broken bones/ fractures	<input type="checkbox"/>	Fibromyalgia/ Chronic Fatigue	<input type="checkbox"/>	<b>Others (explain below)</b>

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.



Is there a chance you may be pregnant at this time?	Yes	No
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Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?	Yes	No			
Please Describe:					
In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive

***If sleep is a problem, answer these questions:***

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

**List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).  
If you are no longer able to perform an activity, your tolerance would be "0".**

Task / Activity	Tolerance (minutes/hours)

I walk for		minutes before needing to rest due to pain
I stand for		minutes before needing to sit due to pain
I sit for		minutes before needing to change positions/get up due to pain
Do you have trouble getting up from a chair?	Yes	No
Do you have trouble putting on your shoes and socks?	Yes	No
Do you have difficulty climbing stairs?	Yes	No

**Patient Goals**

**Please list the activities that you would like to be able to do as a result of therapy.**

Task / Activity	Duration / How Often	By When
<b>Other Goals?</b>		



*Informed Consent*

*I understand that **SPINE PT** will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.*

*Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.*

*I do hereby agree and give my consent for **SPINE PT** to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.*

*I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.*

*I hereby certify that all the above information is true to the best of my knowledge.*

**Patient/Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please bring these forms with you to your appointment or  
email them to: [SpinePTjim@gmail.com](mailto:SpinePTjim@gmail.com)**