OPTIMAL LIVING

LIVE THE LIFE YOU DESIRE.

Name:_____

Address:_____

City:_____Zip:_____

Phone: _____

Email:_____

Emergency Contact: _____

What are you seeking treatment for?

_____

_____

_____

How long have symptoms been going on?

_____

Significant Medical History

(please include surgeries, hospitalizations, anything you think I should know)

_____

_____

_____

In the last year, have you experienced any of the following:

(Please circle those that apply)

High Blood Pressure	Circulation Problems	Diabetes	Hearing Problems
Cancer	Speech Problems	Allergies	Shortness of breath
Kidney Problems	Anxiety	Heart Palpitations	Difficulty Sleeping
Cardiac Condition	Osteoporosis	Difficulty Walking	Pregnancy
Dizzy Spells	Stroke	Fever/Chills/Sweats	Dizziness
Gall Bladder Problems	Fracture	Headaches	Loss of Appetite
Cardiac Pacemaker	Arthritis	Chest Pain	Nausea/Vomiting
Vision Problems	Seizures	Joint Pain or Swelling	Weakness in arms/legs
Depression	Metal Implants	Night Pain	Bladder/Bowel problems

Lifestyle Questions

Do you smoke: Y/N Do you drink alcohol: Y/N

Describe exercise frequency and type:

_____

_____

When was last complete physical:_____

Pain

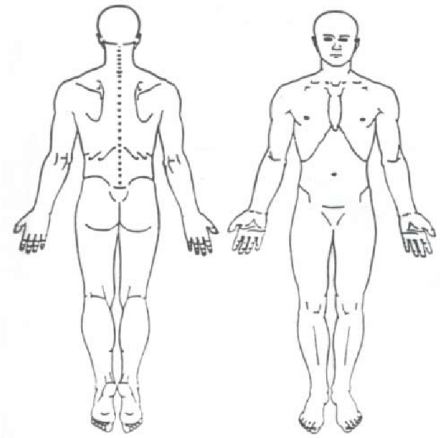
Please rate pain over the last 24 hours 0-10 (0 being no pain at all, 10 being max pain tolerated)

1 2 3 4 5 6 7 8 9 10

Please rate pain range over the last week 0-10 (0 being no pain at all, 10 being max pain tolerated)

1 2 3 4 5 6 7 8 9 10

Please mark on this diagram where you have pain:



Circle best descriptions of your pain:

Dully	Sharp	Pins and needles
Achy	Pressure	Burning
Stabbing	Numbness	Constant

Can you remember when the pain started?

_____

_____

Is there anything else you think I should know?

_____

_____

This signature serves as a consent to treat. You are seeking physical therapy services to address your pain or disfunction. Together we will work toward your goals.

_____

(Please sign)