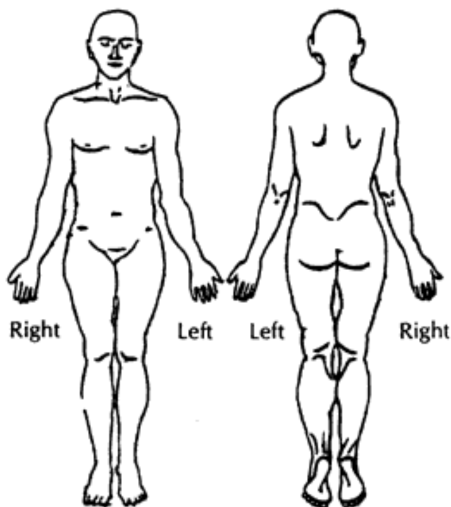
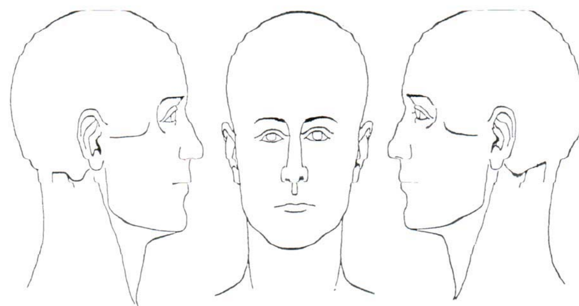
First name ______________________ Middle____________________ Last________________________
Birthdate____/____/_____ Your preferred name__________________ Occupation ____________________
Address_______________________________________City______________State_______Zip_________
Home phone______________ Cell phone________________Email________________________________
Emergency contact__________________________ Phone _______________ Relationship______________

I am seeking help for:____
____
Which is limiting me from: ____
____
When and how did this issue begin?____
____
What are your goals for treatment at Shine?____
____

Please indicate where ALL of your symptoms are on the charts below:





Highest pain level ______ /10 Lowest pain______ /10 Average pain _______ /10
Since onset, are symptoms getting: ___ better? ____ worse? ____ not changing?
What makes your symptom(s) worse?____
What makes it better?____

What other treatment have you had for this condition? Please check all that apply:

__Rest __Massage __Physical therapy __Acupuncture __Surgery __Medication/injection
__Ice __Heat __Orthotics __Osteopathic __Chiropractic __Brace/tape
Other:____
Results or changes from these treatments?____

Why do you think these treatments did or did not help?____

Please check any of the following symptoms you have recently experienced:

__Night pain __Fatigue/weakness __Numbness/tingling __Dizziness ___Fainting
__Weight change __Fever/chills __Vision changes __Loss of bowel/bladder control

Do you currently have or have you had any of the following conditions?

*Please mark with a **C** for current to all that apply. Please mark with a **P** for past issues.*

__Diabetes __Latex allergy __High blood pressure __Diabetes __Neurological issues
__Heart issue __Stomach/GI issues __Impaired thyroid __Cancer __Metal implant/ Pacemaker
__Infectious disease (such as __Hepatitis or __HIV) __Asthma __Sleep apnea
Other:____

Have you had any of the following imaging/tests? __X-ray/CT scan __MRI __other
Result(s) of these tests:____

Physical activities at work/home: ____
How often do you exercise (beyond daily activities)?_____________________________________
How would you describe your general health?____
Either bring a printed list to your PT visit or please list all current meds/supplements:________________
____

List ALL past traumas, concussion, car accidents and surgeries including dates:___________________
____
____

Do you wear: ____glasses ___contacts?

Are your glasses or contacts bifocals or progressives? ___YES ___NO

Do you currently experience: ___Difficulty driving at night ___Blurry vision. ___Double vision ___Eye strain

Does your jaw click or pop when you open or close your mouth? ___YES ___NO

How many headaches do you experience per week? ___0 ___1-2 ___3-5 ___5-7

Do you wear an oral appliance, retainer, or night guard? ___YES ___NO

Do you have custom orthotics, heel lifts or other foot inserts? ___YES ___NO

What types of shoes do you wear most often? ____

Do you experience an abnormal sense of pressure in your abdomen or pelvis? ___YES ___NO

If applicable, list dates you have given birth. Please note with a **C** if they were C-sections: ____________
____

Any other comments or pertinent information you would like to share:__________________________
____
____