SPINE MOUNTAIN
PHYSICAL THERAPY
AND WELLNESS STUDIO

713 Gardenview Drive
Pine Mountain, GA 31822
info@spinemountain.com
Phone: 706-489-3032
Fax: 706-489-3035

DATE: _____

Last Name	**First Name**	**Date of Birth**	**Gender** ☐ Female ☐ Male	
Street Address:		**City**	**State**	**Zip Code**
Primary Phone Number: ☐ Mobile ☐ Landline _____ - _____ - _____		**Email Address:**		
How would you like to receive appointment reminders? ☐ Phone call ☐ Email ☐ Text		**Occupation:**	**Marital Status:**	
Emergency Contact name and relation:		**Emergency Contact Phone:** _____ - _____ - _____		

Referring Physician or Primary Care Physician: _____

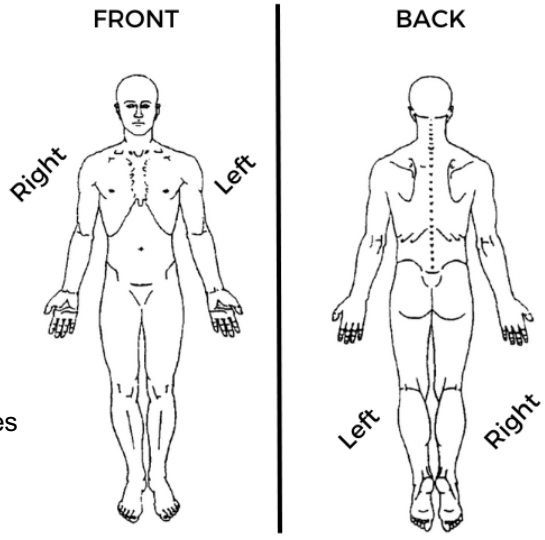
Chief Complaint: Area of injury/symptoms: _____

How did your symptoms start? _____

Date your symptoms/injury started: _____ Date of next visit with physician: _____

Please CIRCLE your CURRENT pain level (0= no pain and 10 = worst pain) 0 1 2 3 4 5 6 7 8 9 10
Pain level at your WORST _____ BEST_____

Using the diagram to the right, color in the specific area of pain/injury.
If pain travels, draw arrows.



Are your symptoms ☐ intermittent or ☐constant?
Do you have any numbness/tingling? ☐No ☐ Yes If yes, where?_____
Do you have any weakness? ☐No ☐ Yes If yes, where?_____

What eases the pain? _____
What aggravates the pain? _____

Have you had any other treatment for this problem? ☐No ☐ Yes
If yes, what: _____ Did it help? ☐No ☐ Yes

Have you had x-rays? ☐No ☐ Yes Findings: _____
Have you had an MRI? ☐No ☐ Yes Findings: _____
Please list any other tests you have received: _____
Women only: Are you pregnant? ☐No ☐ Yes Which trimester? 1____ 2_____ 3_____
Any other concerns or health changes since the start of this injury/illness:
_____

Do you engage in any form of exercise? ☐No ☐ Yes
Frequency and type:_____

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List all your leisure activities and ***CIRCLE*** *those affected* by your current problem:

GENERAL MEDICAL: Check any of the following that you have been diagnosed with or that you experience:

□Heart Disease	□Poor balance	□Cancer (Type:_____)
□High Blood Pressure	□Anemia	□Diabetes (Type 1 or 2: _____)
□Heart Attack	□Seizures/epilepsy	□Headaches
□Stroke	□Digestive disorders	□Tobacco use
□Circulation problems	□Bladder issues	□Depression
□Shortness of breath	□Fibromyalgia	□Anxiety
□Chest pain	□Multiple sclerosis	□HIV
□Asthma	□Osteoporosis	□Hepatitis B
□COPD/Emphysema	□Thyroid disease	□MRSA
□Dizziness	□Liver disease	□Other _____
□Fainting	□Arthritis	□Other _____

Please list any SURGERIES you have had or any INJURIES for which you have been treated.
(Please include approximate dates.)

Surgery or Injury	Approximate Date

Please list ALL PRESCRIPTION and/or OVER-THE-COUNTER medications you are currently taking for this and any other condition (including pills, injections, and/or skin patches).

Medication	Dosage (e.g., 25 mg)	Frequency (e.g., 2x/day)

Do you have an allergy to any medications? □No □ Yes If yes, which ones?
_____

GOALS: What are the activities you want to get back to when you feel better?
_____
_____
_____