ELITELEVELPT.COM

HOME OF THE P.A.S.S. PROGRAM

PERSONAL INFORMATION

Name								Date			
Street			City		State		Zip				
SS#		Drivers License #			State						
D.O.B.		Age		Sex		Single ☐	Married ☐	Divorced ☐	Separated ☐	Widow ☐	
Home Phone		Mobile			Work Phone						
Employer			Occupation								
Emp. Address		City		State			Zip				

HISTORY

Excersise Frequency		Excersise Type			
Do you Smoke		Have you ever smoked		How often	
Are you pregnant		Do you have a pacemaker			
Allergies					
What medications are you currently using					
Previous complaints/ surgeries					
Previoius diagnoses/medication					

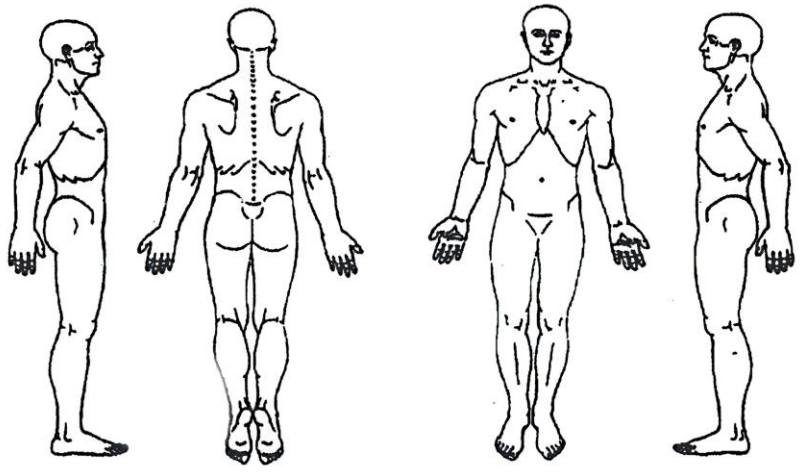
COMPLAINT

What is your major Complaint								
Start date				Possible Cause				
Symptoms								
Previous doctor seen for compaint								
Previous treatment for complaints								
Symptoms-Aggravating Factor								
Symptom-Relieving Factors								
Time of Day Symptoms are best				Time They are Worst				
Current Duration of Pain	Intermittent		Constant		With Certain Motions			
Current Level of Pain	Mild		Moderate		Severe		Excruciating	
Is your pain getting worst				Have you had this injury before				

DO YOU HAVE ANY OF THE FOLLOWING

	AIDS/HIV		Anemia		Angina		Arteriosclerosis
	Arthritis		Asthma		Blood Clots		Bone Infection
	Cancer		Chemical Dependency		Circulation Problems		Depression
	Diabetes		Epilepsy		Eye Infection		Heart Problems
	Hemophilia		High/Low Blood Pressure		Joint/Bone Infection		Liver Problems
	Lung Issues		Multiple Sclerosis		Musculoskeletal Problems		Pneumonia
	Stroke		STD		Tuberculosis		Urinary Infection

MARK AREA OF DISCOMFORT



SIGNATURE		DATE	