PTX therapy

Client Pain History

Client Name: Visit #: Date:

List any symptoms or pain you are experiencing: Level of Pain (1-10)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any major surgeries, accidents and injuries, including sprains and pulled muscles experienced in your lifetime:

List any other health issues:

Are you currently on medications, please list:

What position, if any, increases your pain (sitting, standing, lying down, etc)?

What position, if any, decreases your pain?

Do you have trouble sleeping?

What time of day do you have the most pain? *(please circle)*

Upon Waking | Morning | Afternoon | Evening

Do you feel better or worse with movement?

Better | Worse

What kinds of physical activities are you involved in, and how often?

What are your goals with this program?