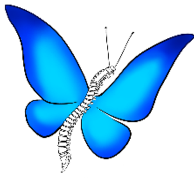


Holland Spine
Physical Therapy, PLC

PHYSICAL THERAPY INTAKE FORM

Name: **Date:**

Mobile: **Home:**

Address: **City:** **Postal Code:**

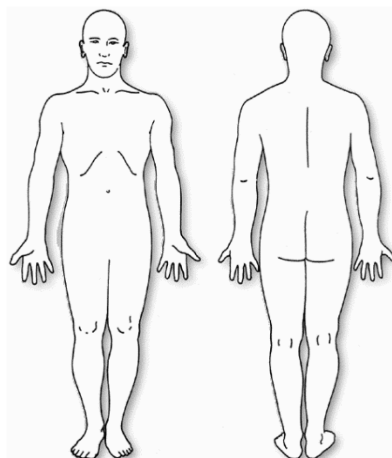
Date of Birth: **Age:** **Marital Status:**

Emergency Contact	**Name:**	**Phone:**
Primary Care Physician	**Name:**	**Date of Next Visit:**
Specialist Physician	**Name:**	**Date of Next Visit:**

Occupation: **Employer:**

The following is important in your evaluation process.
Please fill out these forms as specifically as possible to provide a clear picture of your present pain and functional status.

Please shade in areas where you have pain, discomfort, or tension



What is the primary issue/problem that brings you in here today?

Secondary issue/problem?

As a result, I am now having difficulty with:

Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?

When did your symptom(s) begin?

Please rate your pain in the last 24-72 hours. Using the "0-10" scale where 0 is no pain and 10 is the worst possible pain.

At its worst:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst possible pain)

At its best:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst possible pain)

At present:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst possible pain)

At night (sleeping):

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst possible pain)

At what time of day are your symptoms the worst?

At what time of day are your symptoms the best?

What activities increase your pain?

What activities decrease your pain?

What other types of treatment have you had for this problem?

☐ Injection(s) ☐ Trigger point release ☐ Physical therapy ☐ Massage ☐ Chiropractic ☐ Surgery

☐ X-ray, MRI, CT scan, ultrasound | Date: | Facility:

Check the box if you have had any of the following medical conditions.

☐ Diabetes	☐ Lung disease	☐ Weight change	☐ Varicose veins	☐ Pregnancy
☐ Stroke	☐ Rhematic fever	☐ Osteoporosis	☐ Migraines	☐ Arthritis
☐ Malignancy	☐ Heart murmur	☐ Metal implants	☐ Liver disease	☐ Anxiety/depression
☐ Circulatory problems	☐ Broken bones	☐ Heart disease	☐ Kidney disease	☐ High blood pressure

☐ Neurological problems ☐ Epilepsy/seizures ☐ Pacemaker ☐ Bowel/bladder changes

Others:

List past medical history and dates of occurrence. Include surgeries, accidents, and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. Include supplements, herbal and homeopathic remedies.

Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke? Yes | No

If "Yes" – how much? ______________________________

When did you quit? ______________________________

If not, would you like to quit? Yes | No

Is there a chance you may be pregnant at this time? Yes | No

Do you engage in regular exercise? Yes | No

What type and how often? ______________________________

Are you able to exercise now? Yes | No

Do you have discomfort, shortness of breath, or pain with exercise? Yes | No

Please describe: ______________________________

In general, your lifestyle is:

1	2	3	4	5
Active		Average		Inactive

Do you have trouble falling asleep? Yes | No

Do you find it difficult to change positions in bed? Yes | No

Is your sleep restful? Yes | No

Do you find it difficult to lie down? Yes | No

How many times do you wake in the night? ________________________________

How long before you fall back to sleep? ________________________________

List all the tasks/activities that you have difficulty performing and your tolerance (minutes/hours). If you are no longer able to perform an activity, your tolerance would be "0".

Task/Activity	Tolerance (minutes/hours)

I walk for ___ minutes before needing to rest.

I stand for ___ minutes before needing to sit.

I sit for ___ minutes before needing to change positions/get up.

Do you have trouble getting up from a chair? Yes | No

Do you have trouble putting on your shoes and socks? Yes | No

Do you have difficulty climbing stairs? Yes | No

Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task/Activity	Duration/How Often	By When

Other goals?

____

____

____

How did you hear about this practice?

____

Who can we thank for referring to this practice?

____

Informed Consent

I hereby agree and give my consent for Holland Spine Physical Therapy, PLC to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:_________________

Date:_________________