Physical Therapy Intake Form

Patient information	
Name: Sandra Green	**Date of birth:** February 12, 1980
Gender: Female	**Contact information:** (800) 555-1234
Address: 321 Oak Street, Springfield, IL 62704	
Emergency contact 1	**Emergency contact 2**
Name: Andrew Green	Name: Lucia Brooke
Contact information:	Contact information:
andrewgreen@example.com	luciab@example.com
Referring MD: Dr. Marie Santos	**Family MD:** Dr. Yana Oscar
Insurance information	
Insurance provider: Healthway Insurance	
Policy number: SG12345	**Group number:** 54321
Insurance provider's contact information: healthwayinsurance@example.com	
History	
1. What is your reason for coming to therapy today?	
Chronic lower back pain, particularly after long periods of sitting for work.	
2. When did your problem begin?	
Last June 2024, after lifting a heavy box during a move.	
3. How did your problem start?	
Sharp pain in lower back after lifting a box and has since been dealing with discomfort while sitting, standing, and walking	
4. Please check the appropriate answer:	
a) Do you have high blood pressure?	○ Yes ◉ No
b) Do you currently have an infection?	○ Yes ◉ No
c) Do you have diabetes?	○ Yes ◉ No
d) Do you currently have heart trouble?	○ Yes ◉ No
e) Do you have asthma?	○ Yes ◉ No
f) Do you currently have osteoporosis?	○ Yes ◉ No

g) Do you currently have active cancer?	○ Yes	◉ No	
h) Are you pregnant?	○ Yes	◉ No	○ NA
i) Do you have other health problems?	◉ Yes	○ No	
If **yes**, please list: Mild scoliosis diagnosed in teenage years			
j) Is there anything that your doctor told you not to do?	○ Yes	◉ No	
If **yes**, please list:			
k) Are you currently taking any prescription or over-the-counter drugs?	◉ Yes	○ No	
If **yes**, please list: Occasional ibuprofen for pain relief			
l) Are you currently taking any herbal preparations / vitamins?	○ Yes	◉ No	
If **yes**, please list:			
m) Are you allergic to adhesives/tape, latex, or bee stings?	○ Yes	◉ No	
If **yes**, please list:			
n) Have you had any surgeries?	○ Yes	◉ No	
If **yes**, please list:			
o) Have you had physical therapy previously for the same problem?	◉ Yes	○ No	
p) Are you receiving other treatments for this problem at this time?	○ Yes	◉ No	
If **yes**, please list:			
q) What kind of tests have been done for your current problem? (*check if applicable*)			
☑ MRI ☐ X-Ray ☐ CT Scan ☐ Myelogram			
Or list:			
Results: Results showed mild disc degeneration at L4-L5			
r) Have you been hospitalized in the past year for this condition?	○ Yes	◉ No	
If **yes**, when and for how long?			
s) Does anyone come to your home to provide health care needs (nursing, social work, physical/occupational/respiratory needs)?	○ Yes	◉ No	
t) Do you have any metallic implants (i.e. pacemaker)?	○ Yes	◉ No	
If **yes**, please list: Results showed mild disc degeneration at L4-L5			

Therapist comments:

Posture and alignment will be a focus of treatment, along with strengthening exercises for the core muscles to support her back.

5. When is your next appointment with the doctor who sent you to us?

February 1, 2025

6. Pain

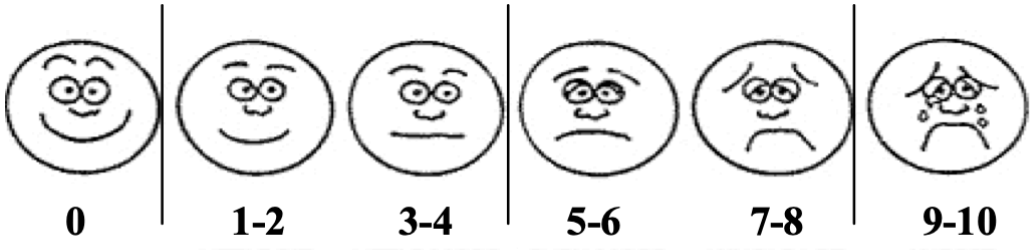
a) Do you have pain now? ○ No ◉ Yes, location/type: Sharp pain/

b) What makes it better? Resting and applying heat

c) What makes it worse? Prolonged sitting or standing.

d) Does the pain interfere with your daily life? ○ No ◉ Yes, describe:

e) Rate your pain on a scale of 0-10 (0 being no pain and 10 being the worst): 6 /10 Today



7. Balance

a) Have you fallen in the last 6 months? ○ Yes ◉ No How many times?

b) Have you had a decrease in your activity level because of a fear of falling? ○ Yes ○ No

c) Are you reluctant to leave your home because of a fear of falling? ◉ Yes ○ No

d) What are your goals as a result of attending physical therapy?

Please check appropriate box.

☑ Decrease pain	☑ Improve strength
☐ Less difficulty with work activities	☐ Stand longer: _____ minutes / hours.
☑ Improve movement	☐ Sit longer: _____ minutes / hours.
☑ Return to recreational activities / sports activities	☐ Less difficulty with home activities
☐ Sleep longer: _____ hours	☐ Anything else:

Physical therapist signature: Dr. John Miller **Date:** 02/05/2025