

# PAR PLUS+

## PHYSICAL THERAPY INTAKE FORM

NAME \_\_\_\_\_ DATE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

LANGUAGE PREFERENCE \_\_\_\_\_

1.) Please check the postures that make up a majority of your day:

Sitting [ ] Standing [ ] Lifting [ ] Bending [ ] Walking [ ] Kneeling [ ] Child care [ ] Other \_\_\_\_\_

2.) HOW did your present pain / problem begin?

\_\_\_\_\_

3.) WHEN did the problem begin? \_\_\_\_\_

4.) Have you had surgery / been in the hospital for your problem? Yes \_\_\_\_ No \_\_\_\_ When \_\_\_\_\_

If yes, surgical procedure \_\_\_\_\_

5.) Are you presently working? Yes \_\_\_\_ No \_\_\_\_ If not, when was your last day? \_\_\_\_\_

6.) Over the last 3 days, the area of your body that is the most painful is \_\_\_\_\_

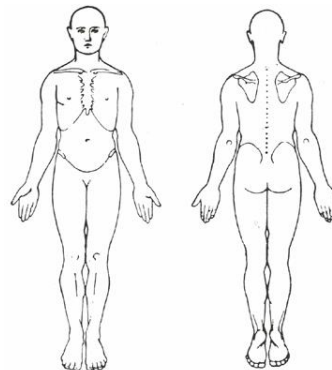
7.) Please check the quality of the pain (check all that apply) Sharp [ ] Dull [ ] Aching [ ] Burning [ ]

Throbbing [ ] Tingling/Numbness [ ] Other \_\_\_\_\_

8.) Please rate your current pain on a '0' to '10' scale ('0' is NO pain '10' is Worst pain imaginable) : \_\_\_\_\_

9.) Please mark on the diagram below the areas in which you are experiencing your pain/symptoms.

### MARK ON THE DIAGRAM



10.) What activities make the pain worse?

a. Exercising [ ]

g. Cough/Sneeze [ ]

b. Sitting [ ]

h. Worse as the day progresses [ ]

c. Standing [ ]

i. Worse in the morning [ ]

d. Walking [ ]

j. Lying down [ ]

e. Bending forward [ ]

k. Other \_\_\_\_\_

f. Bending backward [ ]

\_\_\_\_\_

NAME \_\_\_\_\_

DATE \_\_\_\_\_

11.) What reduces your pain?

- |               |     |                     |     |
|---------------|-----|---------------------|-----|
| a. Lying down | [ ] | g. Chiropractic     | [ ] |
| b. Sitting    | [ ] | h. Physical Therapy | [ ] |
| c. Standing   | [ ] | i. Nothing          | [ ] |
| d. Walking    | [ ] | j. Other _____      |     |
| e. Medication | [ ] | _____               |     |
| f. Injections | [ ] | _____               |     |

12.) Do you have any troubles with your daily and/or recreational activities? Yes \_\_\_\_ No \_\_\_\_

If yes, please list these activities \_\_\_\_\_

13.) Are you currently performing any treatment on yourself? Heat [ ] Ice [ ] Stretching [ ] Braces [ ]

Other [ ] \_\_\_\_\_

14.) Have you had any tests for this problem? CHECK ALL THAT APPLY.

- |             |     |                         |     |
|-------------|-----|-------------------------|-----|
| a. X-rays   | [ ] | d. Discogram            | [ ] |
| b. CAT scan | [ ] | e. EMG/Nerve Conduction | [ ] |
| c. MRI scan | [ ] | f. Other _____          |     |

15.) Please list **ALL** current medications (including over the counter meds): \_\_\_\_\_

16.) Have you recently been in the hospital for other medical problems? Yes \_\_\_\_ No \_\_\_\_

Please specify \_\_\_\_\_

17.) How would you describe your health? Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_

18.) What are your goals with Physical Therapy? \_\_\_\_\_

19.) Do you exercise regularly? Yes \_\_\_\_ No \_\_\_\_ Do you belong to a gym or health club? Yes \_\_\_\_ No \_\_\_\_

Office use only

**THERAPIST SIGNATURE** \_\_\_\_\_