THERAPY INTAKE FORM: *Please fill in all of the fields as completely as you can*

Name: **Date :**

Email: **Phone Number :**

PERSONAL INFORMATION

Gender: ◯ M ◯ F **Birthday:**

Height: **Weight:** **Pregnancy Due Date (if applicable):**

PAIN

What Hurts? (List worst 2 pain areas on your body):
Right knee, low back, front of hip, etc.

	Worst Pain:	**Secondary Pain:**
Pain level (1-10):		
Does Your Pain include Nerve Referral (tingling, numbness)?	◯ Yes ◯ No	◯ Yes ◯ No
If you have nerve referral, is it the worst thing about your pain?	◯ Yes ◯ No	◯ Yes ◯ No
How Long Have You Had This Symptom (days, months, years)?		
List any diagnosis you have been given:		

List any movements that INCREASE pain:
Select all that apply

- ☐ Sitting
- ☐ Standing
- ☐ Lifting Arms
- ☐ Squatting
- ☐ Lying Down
- ☐ Twisting
- ☐ Bending
- ☐ Other:
- ☐ Walking
- ☐ Running
- ☐ Up or Down Stairs

Describe any additional pains:

List any muscle or joint surgery you've had in the **past 6 months**:

List any muscle or joint surgery you're **considering in the next year**:

Have you had any of the following **in the past year:** ☐ MRI or CT ☐ X-Ray ☐ Pain Injections ☐ Brace or Orthotics

Are you **considering** getting any of the following treatments: ☐ MRI or CT ☐ X-Ray ☐ Pain Injections ☐ Brace or Orthotics

Are you currently taking any pain medications?

- ☐ Prescription
- ☐ Over-the-Counter

How many weeks, months or year have you been taking them?

Are you seeing any specialists for your pain?
If So, How many visits in the last year?

- ☐ Doctor — Visits Per Year
- ☐ PT — Visits Per Year
- ☐ Chiropractor — Visits Per Year

How many days in the last year have you missed work due to your symptoms:

How much is your pain affecting you emotionally and mentally? (on a scale of 0-10, 10 being worst)

Do you have a known heart condition?
◯ Yes ◯ No

Check off all the health conditions that apply:

- ☐ Diabetes
- ☐ Heart Palpitations
- ☐ Night Sweats
- ☐ Ringing In Ears
- ☐ Blackout Spells
- ☐ Shortness Of Breath
- ☐ Circulation Problems
- ☐ Dizziness / Vertigo
- ☐ Digestive Problems
- ☐ Fatigue
- ☐ Sleeping Problems
- ☐ None Of The Above

HOW I MOVE

What best describes your balance?

- ◯ Completely Balanced
- ◯ Somewhat Balanced
- ◯ Not At All Balanced

What best describes your walking?
Select all that apply

- ☐ Nice Long Strides
- ☐ Short Strides
- ☐ I Shuffle
- ☐ I Waddle Side To Side
- ☐ I Lean Forward
- ☐ No Power in Hips or Legs

Do you use any of the following?

- ☐ Wheelchair — *Sometimes, Most of the Time, All the time?*
- ☐ Walker — *Sometimes, Most of the Time, All the time?*
- ☐ Cane — *Sometimes, Most of the Time, All the time?*

How hard is it to do the following:

Rising from sitting in a chair:	◯ Easy	◯ Struggle	◯ Impossible
Rising from sitting on a couch:	◯ Easy	◯ Struggle	◯ Impossible
Going up or down stairs:	◯ Easy	◯ Struggle	◯ Impossible
Getting down on the floor and back up:	◯ Easy	◯ Struggle	◯ Impossible

If getting back to the floor is a struggle or impossible, why is it?

- ◯ *Hurts Too Much*
- ◯ *Not Enough Stregth*
- ◯ *Afraid Of Not Getting Up*

If getting back to the floor is a struggle or impossible, when was the last time you got on the floor and back up?

- ◯ *Within the past month*
- ◯ *Within the past year*
- ◯ *It's been years*

MY POSTURE & FITNESS

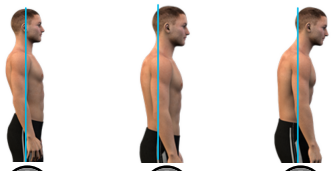
Select one answer for each of the following questions:

When standing, is your low back more arched or more flat?

More arched ◯ 

More flat ◯ 

Which image best represents your head and shoulders?



◯ ◯ ◯

Do you have a slight twist in your hips or shoulders?

◯ Yes ◯ No

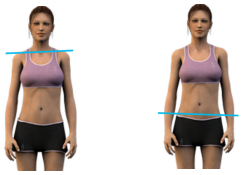
What does your side hip position look like?

- ◯ Straight
- ◯ Slightly Forward
- ◯ More Forward

Which image best represents your foot position?

Both feet straight ◯ One foot turns out ◯ Both feet turn out ◯

Do you have a slight elevation in your hips or shoulders?



◯ Yes ◯ No

What best describes your daily work / tasks?

- ◯ Mostly Standing
- ◯ Mostly Sitting

Rate your overall body flexibility / range of motion:

- ◯ Good
- ◯ OK
- ◯ Poor

What best describes your OVERALL activity / strength **over the course of your life**?

- ◯ Very Active
- ◯ Active
- ◯ Moderate Movement
- ◯ Limited Activity

What best describes your OVERALL activity / strength **over the the last 6 months**?

- ◯ Very Active
- ◯ Active
- ◯ Moderate Movement
- ◯ Limited Activity

ADDITIONAL INFORMATION

Is there a position that helps to ease your pain or symptoms? (sitting, lying down, etc.)

What is a short term goal?

What is a long term goal, or something that you would consider miraculous?

What is the best way to contact you?