

Patient Registration

**BACK TO ACTION  
PHYSICAL THERAPY  
PLC**

Waitsfield Vermont

**PHYSICAL INTAKE FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Which area of the body is your chief complaint? \_\_\_\_\_

Were you referred to physical therapy by a doctor (circle one)? Yes No  
If yes, doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of next visit with referring physician: \_\_\_\_\_

Have you had any x-rays or diagnostic testing regarding this condition (please list): \_\_\_\_\_

Briefly describe when you have pain; or the most painful activities that you would like to do without pain: \_\_\_\_\_

|                              |  |       |       |                                   |
|------------------------------|--|-------|-------|-----------------------------------|
| <b>HEALTH HISTORY:</b>       | Do you have or have you had any of the following (check one column for each question): | YES   | NO    |                                   |
| Allergies                    |  | _____ | _____ | Allergic to: _____                |
| Coronary Heart Disease       |  | _____ | _____ | Do you take nitroglycerin? Yes No |
| High Blood Pressure          |  | _____ | _____ |                                   |
| Diabetes                     |  | _____ | _____ |                                   |
| Cancer                       |  | _____ | _____ | If yes, where/type? _____         |
| Unexplained weight loss/gain |  | _____ | _____ |                                   |

**PAIN:**  
Do you have any waking night pain? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many times a night? \_\_\_\_  
My pain is (circle one): constant intermittent  
Please rate your pain on a scale from one to ten where 0 is no pain, 1-3 is mild pain, 4-7 is moderate pain, 8-10 is severe pain): 0 1 2 3 4 5 6 7 8 9 10

Have you had any accidents (please explain):  No accidents since last visit  
\_\_\_\_\_  
\_\_\_\_\_

Please list all surgeries that you have had:  No surgeries since last visit  
\_\_\_\_\_  
\_\_\_\_\_

List any prescription medication that you are taking:  No change since last visit  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_