PROACTION
PHYSICAL THERAPY

Patient Intake Form

Please complete every section. Print clearly in ink.

Patient Name

Today's Date

1 Reason for Visit

Tell us about your visit and any relevant injury history

Body area(s) affected (e.g., left knee, lower back)

Discipline (e.g., Physical Therapy)

Injury / Illness Date (mm/dd/yyyy)

Year of injury, if recalled

Have you had recent surgery for the primary condition you are being seen for?

☐ Yes ☐ No

Is your condition related to any of the following? Each row is independent — mark every "Yes" that applies.

a. Employment (current or previous)?	☐ Yes	☐ No
b. Auto accident?	☐ Yes	☐ No
c. Other accident?	☐ Yes	☐ No

2 Pain

Rate your current pain level

On a scale of 0 to 10, where 0 = no pain and 10 = worst pain imaginable:

Current pain (0-10)

Best (0-10)

Worst (0-10)

Pain location(s)

3 Personal & Contact Info

Basic demographic, contact, and emergency details

Basic Information

First Name

Last Name

Date of Birth (mm/dd/yyyy)

Gender

Residential Address

Street Address

City

State

ZIP Code

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Contact Information

Email Address

Phone Number (10-digit)

Emergency Contact

Name

Relationship

Phone (10-digit)

4 Insurance

Health insurance details

Do you have health insurance?

☐ Yes ☐ No

Insurance Provider (e.g., Blue Cross Blue Shield)

Policy Number

Group Number

Policyholder / Cardholder

Is the policyholder the same as the patient?

☐ Yes — same as patient ☐ No — complete the cardholder fields below

Cardholder First Name

Last Name

Date of Birth

Relationship to Patient

Address

Address 2

City

State

ZIP

5 Medications

Medications you are currently taking

Are you currently taking any medications?

☐ No, I am not taking any medication
☐ Yes — I have listed them below
☐ Yes — I will bring a list to my appointment

Current Medications

Medication Name	Dose	Frequency

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6 Medical History

Your past and current medical conditions

Medical Conditions (check all that apply)

- ☐ Diabetes
- ☐ Asthma
- ☐ COPD
- ☐ Anxiety
- ☐ None of the above
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Thyroid Disorder
- ☐ Osteoporosis
- ☐ Heart Disease
- ☐ Cancer
- ☐ Depression
- ☐ Fibromyalgia

Orthopedic & Neurological History (check all that apply)

- ☐ None of these apply to me
- ☐ Pins / Metal Implant(s)
- ☐ Numbness / Tingling / Neuropathy
- ☐ Joint Replacement(s)
- ☐ Arthritis

If joint replacement or implant, please specify:

Affected area(s) _____

Side (Left / Right / Both) _____

Lifestyle

How often do you exercise?

- ☐ Never
- ☐ Usually twice per week
- ☐ 4 or more times per week
- ☐ Usually once a week
- ☐ Usually 3 times per week

Does your daily routine or work aggravate your condition?

- ☐ No
- ☐ I am unable to participate in my normal routines or work
- ☐ Aggravates my condition 1 day per week
- ☐ Aggravates my condition 3 or more days per week
- ☐ Aggravates every day, but I try to cope

Functionality

Does your condition impact your ability to do your job?

- ☐ I am retired
- ☐ I can only work part time
- ☐ I can work, with minor difficulty
- ☐ Not applicable
- ☐ The condition prevents me from working
- ☐ I can work, but with great difficulty
- ☐ The condition does not impact my ability to work

Does your condition impact your ability to attend school?

- ☐ The condition prevents me from attending school
- ☐ In school and the condition has minor impact
- ☐ School is normal, no impact
- ☐ In school, but the condition has a big impact
- ☐ School is normal, but I can't participate in sports
- ☐ Not applicable

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7 Personal Health

Your physical health, fall risk, and wellness

Height & Weight

Height — Feet _____ **Height — Inches** _____ **Weight (lbs)** _____

Fall Risk Assessment

Have you fallen in the past year?

- ☐ No
- ☐ Yes, once
- ☐ Yes, twice
- ☐ Yes, 3 or more times

Are you afraid of falling?

- ☐ No
- ☐ Sometimes
- ☐ Often
- ☐ Always

Do you feel unsteady when walking or standing?

- ☐ No
- ☐ Sometimes
- ☐ Often
- ☐ Always

Do you use an assistive device (cane, walker, wheelchair)?

- ☐ No
- ☐ Yes, a cane
- ☐ Yes, a walker
- ☐ Yes, a wheelchair
- ☐ Yes, other

Wellness Screening

How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How would you rate your sleep quality?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

How would you rate your current stress level?

☐ None ☐ Mild ☐ Moderate ☐ High ☐ Severe

Do you currently use tobacco products?

- ☐ No, never
- ☐ No, former user
- ☐ Yes, occasionally
- ☐ Yes, daily

How often do you consume alcoholic beverages?

- ☐ Never
- ☐ Rarely (a few times a year)
- ☐ Monthly
- ☐ Weekly
- ☐ Daily

By signing below, I confirm the information provided is accurate to the best of my knowledge.

Patient / Guardian Signature _____ **Date** _____