



# HSS Spine & Sport Patient Intake Form

Date \_\_\_\_\_  
MR # \_\_\_\_\_

1. Name \_\_\_\_\_  
Last First MI Jr/Sr

How do you wish to be addressed? \_\_\_\_\_

2. Preferred contact phone # \_\_\_\_\_

3. May we contact you via e-mail?  Yes  No

If so, please list E-mail address: \_\_\_\_\_

4. Date of birth / / 5.  Male  Female

6. Language: English understood?  Yes  No  
Interpreter needed?  Yes  No

What language do you speak most often? \_\_\_\_\_

### 7. Employment:

- Employed - Occupation \_\_\_\_\_
- On disability - Occupation \_\_\_\_\_
- Unemployed  Retired
- Student  Not yet working age

8. Who referred you to therapy? \_\_\_\_\_

9. Have you seen anyone else for this problem?  
 Yes  No If yes, who? \_\_\_\_\_

10. Have you had other therapy this year?  
(i.e. OT, PT, speech, psychological)  Yes  No

11. What is your goal for therapy?  
\_\_\_\_\_

12. What are your current activities & frequency?  
\_\_\_\_\_

13. Have you ever had surgery?  Yes  No  
If yes, please describe & include dates: (con't on back pg if needed)  
\_\_\_\_\_  
\_\_\_\_\_

14. Medications - Do you take any non-prescription medications (check all that apply)  None

<input type="checkbox"/> Advil/Motrin/Ibuprofen	<input type="checkbox"/> Aspirin/Bufferin
<input type="checkbox"/> Aleve/Naprosyn/Naproxen	<input type="checkbox"/> Decongestants
<input type="checkbox"/> Antacid	<input type="checkbox"/> Supplement/vitamin
<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Tylenol
<input type="checkbox"/> Other _____	

Do you take prescription medications?  Yes  No  
If yes, please list: \_\_\_\_\_

15. General Health Please rate your health:

Excellent  Good  Fair  Poor

Have you had any recent major life changes (i.e. new baby, job change, death of loved one)?  Yes  No

16. Have you had any of the following in the past year?

- Bone scan  EKG (electrocardiogram)
- CT scan  EMG (electromyography)
- Ultrasound  MRI
- X-rays  Other \_\_\_\_\_

17. Are you allergic or sensitive to:

latex  Yes  No adhesive tape  Yes  No

Do you have any other significant allergies?  Yes  No

If yes, please list: \_\_\_\_\_

### 18. Medical History/THERAPY PRECAUTIONS

Please check if you've ever had, or *currently* have:

- |   |   |
|---|---|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> High Blood Pressure            |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Sugar/Diabetes      |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Low Blood Sugar (hypoglycemia) |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Osteoporosis                   |
| <input type="checkbox"/> Head Injury    | <input type="checkbox"/> Seizures/Epilepsy              |
| <input type="checkbox"/> Heart Problems |   |
| <input type="checkbox"/> Other _____    |   |

Have you had any other physical problems in the past year we should be aware of? (i.e. shortness of breath, insomnia, dizziness): \_\_\_\_\_

19. Current limitations (Check all that apply)

- Difficulty with  movement  transfers
- Difficulty with walking:  on levels  on stairs
- endurance/distance  on uneven surfaces
- Difficulty with self-care (i.e. bathing, dressing, eating)
- Difficulty with home management (i.e. household chores, shopping, driving/transportation)
- Difficulty during recreation or play activities

Do you need to use any of the following?

- Hand held support  Cane
- Crutches  Walker with / without wheels (circle)
- Stroller  Wheelchair manual / power (circle)
- No devices needed for mobility

20. Where do you live?

- House  Assisted living / group home
- Apartment  Homeless (with or without shelter)
- Other: \_\_\_\_\_

Please describe your home situation:

- No stairs  Stairs, no rail(s)
- Stairs, with rail(s)  Ramps
- Elevator  Uneven terrain

### FOR THERAPIST USE ONLY:

SAFETY ISSUES:

- BALANCE/FALL RISK  COGNITIVE  HEARING
- MEMORY  POSITIONAL ISSUE  VISION
- OTHER: \_\_\_\_\_

Pre/Post Treatment Considerations Reviewed & Discussed with patient

Therapist Signature \_\_\_\_\_

Printed Name \_\_\_\_\_