

**COLUMBIA UNIVERSITY MEDICAL CENTER**  
**The Spine Center**  
**PHYSICAL THERAPY PATIENT INTAKE**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

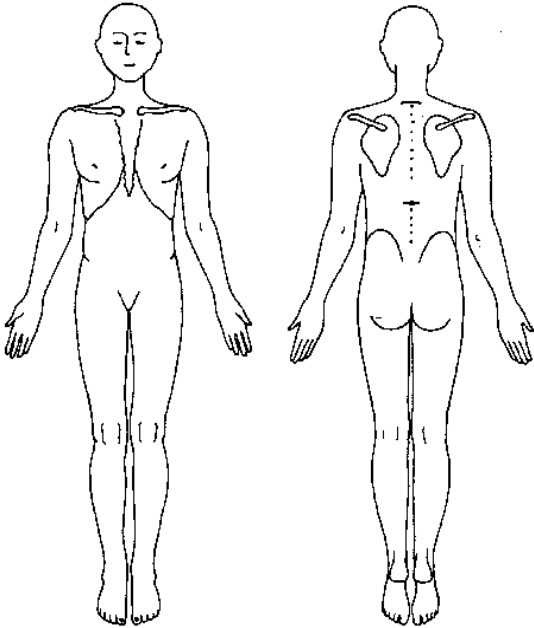
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height (ft., in.) \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_

Referring Physician \_\_\_\_\_ Specialty \_\_\_\_\_ Next visit scheduled \_\_\_\_\_

What is your chief complaint? \_\_\_\_\_

When did the problem begin? \_\_\_\_\_

How did the problem begin? \_\_\_\_\_



**Please draw your symptoms on the chart.**

Key:

*Pain: (XXXXX)*

*Numbness/tingling: (//////////)*

*Muscle Spasm: (ZZZZZZ)*

*Radiating symptoms: (->->->->-)*

**Please rate your pain on a scale of 0-10.**

(0=no pain, 10=requires Emergency Room visit):

Currently \_\_\_\_\_

At best, in the last 72 hours \_\_\_\_\_

At worst, in the last 72 hours \_\_\_\_\_

What makes it feel better? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_

Are your symptoms (check one): stable \_\_\_\_\_ getting better \_\_\_\_\_ getting worse \_\_\_\_\_

Have you had any treatment for this problem? (describe): \_\_\_\_\_

Are you currently working? If so, what is your occupation? \_\_\_\_\_

Are you (check one): single \_\_\_\_\_ co-habiting \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_ widowed \_\_\_\_\_

Do you have a lawsuit or worker's compensation claim related to your injury? \_\_\_\_\_

Have you recently experienced any of the following?

Weight loss/gain	YES	NO	Dizziness/Lightheadedness	YES	NO
Nausea/Vomiting	YES	NO	Unusual Weakness	YES	NO
Fatigue	YES	NO	Fever/Chills/Sweats	YES	NO

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Have YOU ever been diagnosed with any of the following?

Heart Disease	YES	NO
High Blood Pressure	YES	NO
Stroke	YES	NO
Anemia	YES	NO
Circulation Problems	YES	NO
Tuberculosis	YES	NO
Epilepsy	YES	NO
Headaches/Migraines	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Arthritis	YES	NO
Depression	YES	NO
Kidney Disease	YES	NO
Alcoholism/Chemical Dependency	YES	NO
Other _____		
Other _____		

Has anyone in YOUR IMMEDIATE FAMILY (parents/brothers/sisters) ever been treated for any of the following?

Heart Disease	YES	NO
High Blood Pressure	YES	NO
Stroke	YES	NO
Anemia	YES	NO
Circulation Problems	YES	NO
Tuberculosis	YES	NO
Epilepsy	YES	NO
Headaches/Migraines	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Arthritis	YES	NO
Depression	YES	NO
Kidney Disease	YES	NO
Alcoholism/Chemical Dependency	YES	NO
Other _____		
Other _____		

Please list any surgeries or hospitalizations you have had, with the date and reason:

DATE	SURGERY/HOSPITALIZATION	DATE	SURGERY/HOSPITALIZATION
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Please list any injuries you have had (broken bones, dislocations, sprains/strains):

DATE	INJURY	DATE	INJURY
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Please list all prescription medications you are currently taking:

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Do you have an allergy to latex? \_\_\_\_\_

Do you have any special equipment? (canes, crutches, walker, exercise equipment) \_\_\_\_\_

Do you do any regular exercise? If so, describe: \_\_\_\_\_

Do you smoke cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_ How many packs a day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ How much do you drink at an average sitting? \_\_\_\_\_

How many cups of coffee or caffeine containing beverages do you drink per day? \_\_\_\_\_