

Spine and Back Rehabilitation Intake Form

Personal Information

Full Name

Date of Birth

Phone

Email

Address

Referring Physician

Physician Name

Physician Contact

Presenting Complaint

Briefly describe the reason for your visit

Location of pain/discomfort

Duration of symptoms

What makes it worse?

What makes it better?

Medical History

Relevant medical conditions

Previous surgeries (especially spine/back)

Current medications

Allergies

Pain Assessment

Pain level (0-10)

Type of pain

Mobility and Function

Activities limited by pain

Do you use any assistive devices?

Additional Notes

Anything else you would like to share?