

Date: _____

Personal intake form | Sporting Spine Regensburg



This questionnaire collects the necessary information that we need in order to provide you with the best possible, personally tailored support. Please take the time to process it correctly. Thanks very much!

Name: _____ Address: _____

Location please: _____

Tel. Private: _____ Health insurance: _____

Mobile: _____

E-mail address: _____

Birth date: _____

Regular occupation: _____

How did you find out about our practice?: _____

Have you ever been treated by a physical therapist before?

Yes No ___

How would you personally describe your current main problem:

When did this problem start?

(Please define as precisely as possible - month, year, day)

If you are in pain - what makes your pain worse?

When you are in pain - what relieves your pain?

What time of the day or week is your pain worse?

In case of pain problem:

The pain is: Always present: _____ Interrupted (inconstant) present: _____

(Please tick as appropriate)

Did you have this problem before this episode of pain?

If yes, how often? _____

Do you think your pain is related to an accident?

Do you think your pain is related to a work-related stress?

Please list any previous injuries, serious illnesses, surgeries or hospitalizations:

Date or Age: _____

Date or Age: _____

Date or Age: _____

Date or Age: _____

Date or Age: _____

Do you or any of your family members have or have you had any of the following diseases (please tick one box for each – only if it applies!):

Arthritis Myself____ Family member_____

Lung diseases (asthma, bronchitis, etc.) Myself____ Family member_____

Cancer Myself____ Family member_____

Diabetes Myself____ Family member_____

heart disease Myself____ Family member_____

high blood pressure Myself____ Family member_____

Recurrent hypoglycaemia Myself____ Family member_____

kidney disease Myself____ Family member_____

depression Myself____ Family member_____

Diagnosed mental illness

Myself____ Family member_____

Infectious diseases (hepatitis, AIDS) Myself____ Family member_____

What medications, herbs, dietary supplements, vitamins do you take?

Please list names and reason for taking:

Please list any allergies you suffer from:

III) Activity Tolerance

2. How high do you estimate the probability that you will be able to carry out your usual activities and work again within 6 months without any problems:

Very sure 0 1 2 3 4 5 6 7 8 9 10 Not at all sure (impossible)

3. Physical activity makes my problems worse!

Strongly disagree 0 1 2 3 4 5 6 7 8 9 10 Strongly agree

4. What specific daily activities cause you the most trouble. Please rate the pain from 0 (no pain) to 10 (you go to the hospital voluntarily)

1: _____	Pain level: _____
2: _____	Pain level: _____
3: _____	Pain level: _____
4: _____	Pain level: _____
5: _____	Pain level: _____
6: _____	Pain level: _____
7: _____	Pain level: _____

I would like my therapist to contact me by phone or e-mail after the treatment or in between as part of the further support and target agreement: yes _____ no _____

Unexcused absences are a financial problem for us as a practice. With my signature, I accept the regulation that I will receive an immediate, unannounced cancellation invoice for appointments that are unexcused, not attended and not canceled.

I hereby confirm the accuracy and completeness of the information. As a physiotherapeutic company, the Sporting Spine practice and all employees are subject to medical confidentiality regarding personal data. This confidentiality also applies beyond the care for life.

Name: _____ Date: _____

Signature: _____ (required)

Voluntary part:

We will be happy to provide you with the latest updates 100% free of charge by email **information for your health**, you otherwise in this great Difficult or impossible to get quality.

This is what you get from us in concrete terms:

- **Health information (also disease-specific)**
- News from our practice
- **Special offers (e.g. eBooks, new courses, etc.)**

Do you, like many others, not want to miss anything?

With my signature, I agree that the Sporting Spine Regensburg practice may regularly send me interesting health information and current practice offers.

I can withdraw my consent to this from Sporting Spine at any time. Information by email or telephone is sufficient for this.

My data will under no circumstances be passed on to third parties and will be processed and managed with the greatest possible care in accordance with the GDPR.

YES! I would like to be included in the newsletter: _____

Signature

This questionnaire is copyrighted and may not be reproduced without permission.- Sporting Spine 2023