



Boomerang Therapy Works

Physical Therapy Intake Form

Personal Information

Name: Andrea Sample Date: 10/22/2025
 Address: 123 Main Street
 Phone: 360-867-5309 Email: andrea.kropp@landing.ai
 DOB: 7/31/70 Sex: F Who Referred You? PCP

History

Exercise Frequency: ~5 times/wk Exercise Type(s): Tennis, Crossfit
 Do you have a Pacemaker? Yes No Allergies:
 What medications are you currently using? multivitamins only
 Complaints/Surgeries _____

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Questions: (Circle Yes or No)

- Has your doctor ever said that you have a heart condition and that you should only perform physical activities recommended by a doctor? Yes No
- Do you feel pain in your chest when you perform physical activities? Yes No
- In the past month, have you had chest pain when you were not performing any activity? Yes No
- Do you lose your balance because of dizziness or do you ever lose consciousness? Yes No
- Do you have bone or joint problems that could be made worse by a change in your physical activities? Yes No
- Is your doctor currently prescribing any medications for your blood pressure or for a heart condition? Yes No
- Do you know of any other reason why you should not engage in physical activity? Yes No

Do you have any of the following? (Circle All That Apply)

HIV/AIDS
Arthritis
Cancer
Diabetes
Hemophilia
Lung Issues
Stroke

Anemia
Asthma
Chemical Dependency
Epilepsy
High/Low Blood Pressure
Multiple Sclerosis
STD

Angina
Blood Clots
Circulation Problems
Eye Infection
Joint Infection
Musculoskeletal Problems
Tuberculosis

Arteriosclerosis
Bone Infection
Depression
Heart Problems
Liver Problems
Pneumonia
Urinary Infection



Andrea Sample
Patient/Guardian/Responsible Party Signature

10/22/25
Date