PHYSICAL THERAPY INTAKE FORM

Disclaimer: Thank you for your interest in being a client of .
Information collected about new clients is confidential and will be treated accordingly.

PATIENT INFORMATION

Full Name: _____ **Email**: _____

Address: _____

Phone: _____ **DOB**: _____ **Age**: _____ **Gender:** _____

Preferred Contact Method: ☐ E-mail ☐ Phone ☐ Text Message

Emergency Contact: _____ **Phone**: _____

Emergency Contact Relationship: _____

Employer: _____ **Occupation:** _____

Referred by: _____

INSURANCE INFORMATION

Primary Insurance Company: _____
Group #: _____ ID#: _____
Policyholder Name: _____ DOB: _____
Relationship to Patient: _____

Secondary Insurance Company: _____
Group #: _____ ID#: _____
Policyholder Name: _____ DOB: _____
Relationship to Patient: _____

REFERRING PHYSICIAN

Referring Physician: _____ **Phone:** _____
Date of next visit with referring physician: _____

Primary Care Physician: _____ **Phone:** _____

PATIENT INJURY OR CONDITION

Height: _____ **Weight:** _____

Type of Injury/Condition: _____
Date of Injury/Onset: _____

Type of Surgery/Procedure: _____
Date of Surgery: _____

Please describe your physical limitations as a result of this injury/surgery:

Please describe any activities or movements that aggravate your symptoms:

Please describe any treatments, movements, or self-care that decrease your symptoms:

Please list any previous injury, conditions, or surgeries:

Have you had any of the following diagnostic tests in relation to this injury?
☐X-Ray ☐MRI ☐CT Scan ☐Doppler ☐Ultrasound ☐Other: _____

Which of the following describes your pain? (check all that apply)
☐Sharp ☐Achy ☐Burning ☐Tingling ☐Numbness ☐Other: _____

Are you currently taking any medications? ☐Yes ☐No
Please list all medications and dosages:

Please rate your pain: *(0=None, 5=Moderate, 10=Severe)*

At present: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
At best: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
At worst: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Is your injury the result of a fall? ☐Yes ☐No

Have you fallen twice or more in the past year? ☐Yes ☐No
Dates of falls: _____

PATIENT MEDICAL HISTORY

Have you been diagnosed with any of the following conditions? (check all that apply)

☐ Allergies	☐ Diabetes	☐ Metal implants
☐ Anemia	☐ Dizziness/vertigo	☐ Multiple sclerosis
☐ Anxiety	☐ Emphysema/Bronchitis	☐ Neurological disorder
☐ Arthritis	☐ Fibromyalgia/Chronic fatigue	☐ Numbness/tingling
☐ Asthma	☐ Fractures	☐ Osteoporosis/Osteopenia
☐ Bladder/Bowel problems	☐ Gastrointestinal problems	☐ Pain syndrome/CRPS
☐ Cancer	☐ Gallbladder/Kidney problems	☐ Parkinson's
☐ Cardiac disease/conditions	☐ Headache/Migraines	☐ Seizures
☐ Pacemaker/defibrillator	☐ Hepatitis	☐ Speech problems
☐ Circulation problems	☐ Hernia	☐ Strokes
☐ Currently pregnant	☐ High blood pressure	☐ Thyroid problems
☐ Depression	☐ Incontinence	☐ Vision problems

Please describe in detail any diagnosis checked above:

Have you suffered from any illness not listed here? ☐ Yes ☐ No
If yes, please explain:

TREATMENT HISTORY

Have you been treated for this condition before? ☐ Yes ☐ No
If yes, by whom? _____ Was it helpful? ☐ Yes ☐ No

What are your goals for Physical Therapy?

What do you hope to get out of your treatment?

What are your current physical or fitness goals?

Please list any important dates, such as return to sport/performance/games, coming up for which you want to be physically ready: _____

Is there anything else that you would like to include or ask your therapist?

HEALTH HABITS & LIFESTYLE

Do you eat a well-balanced diet? ☐ Yes ☐ No

Do you drink water regularly? ☐ Yes ☐ No If yes, how many glasses per day? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, how many times per week? _____
Exercise type/program: _____

Do you have any hobbies/leisure activities? ☐ Yes ☐ No Type: _____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____
For how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many per week? _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, hereby agree and give my consent for the physical therapist named in this document to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ (Patient initial)

> FOR MINORS ONLY: CONSENT FOR CARE: As parent and/or legal guardian, I authorize the physical therapist named in this document to treat the minor patient named in the attached forms while I am not present. _____ (Parent/Guardian initial)

By signing below, I agree that all of the above information is correct, and that I authorize the physical therapist named in this document to provide me with therapy services and to furnish my physician, insurance company or attorney information concerning my injury and treatment.

CLIENT SIGNATURE

Signature: _____ Date: _____

Print Name: _____