Physical Therapy Intake Form

Demographics

Patient Name ____________________

Date of Birth ____________ Physician ____________

Address ____________________

Phone # ____________ Email ____________

Emergency contact name ____________ Phone # ____________

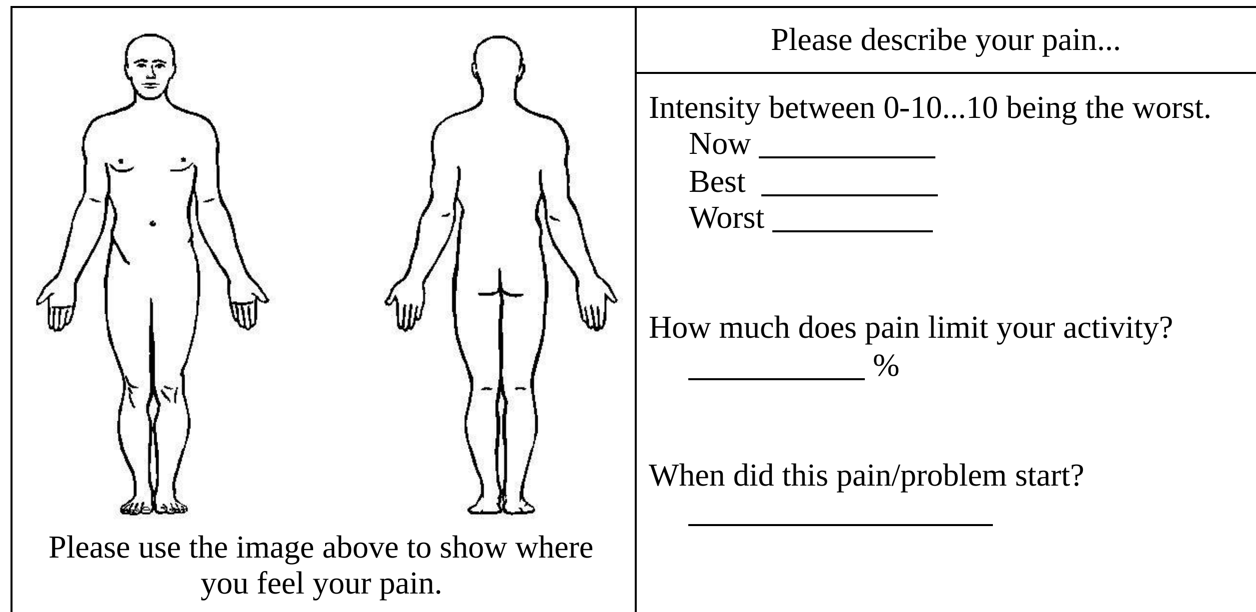
How did you hear about us? ____________________

Medical History

Past Medical History (please check all that apply)		
☐ Asthma	☐ Cancer	☐ Blood clot
☐ Anxiety	☐ Gout	☐ Stroke
☐ Fibromyalgia	☐ Diabetes	☐ Heart problems
☐ Sleep problems	☐ Seizures	☐ Osteoporosis
☐ Migraines/headache	☐ Pacemaker	☐ Pins/metal implants
☐ High blood pressure	☐ Varicose veins	☐ Rheumatoid Arthritis
☐ Pregnancy	☐ Neurologic disorder	☐ Depression
☐ Anemia	☐ Concussion	☐ Infectious disease
☐ Visual dysfunction	☐ Allergies	
If you checked any of the above, please provide further information…		
Please list any medications that you are currently taking.		

Have you experienced any of the following recently?..		
☐ Chest pain ☐ Pain w/ or after meals ☐ Memory problems ☐ Difficulty speaking ☐ Shortness of breath ☐ Unexplained weight loss	☐ Nausea/vomiting ☐ Dizziness ☐ Vision changes ☐ Poor balance/falls ☐ Change in appetite ☐ Increased pain at night/rest	☐ Confusion/brain fog ☐ Change in bladder habits/control ☐ Difficulty swallowing ☐ Fever/chills/sweats ☐ Unusual weakness ☐ Numbness and tingling
If you checked any of the above, please provide further information… ______________________________ ______________________________ ______________________________		

Pain



Please use the image above to show where you feel your pain.	Please describe your pain...
	Intensity between 0-10...10 being the worst. Now ____________ Best ____________ Worst ___________ How much does pain limit your activity? ____________ % When did this pain/problem start? _____________________

What made you seek out physical therapy?

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Please check any services that have been performed related to this condition.	
☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Other imaging ____________________	☐ Physical Therapy ☐ Chiropractor ☐ Acupuncture ☐ Massage Therapy ☐ Personal trainer

Please list any positions/activities that you currently have difficulty with.	Please list anything that currently provides you relief (example: positions, medication, stretch, hot/cold)
1. 2. 3. 4. 5.	1. 2. 3. 4. 5.

What are your goals for physical therapy?
____ ____ ____ ____ ____

Please provide any other information that you feel may be important for your therapist to know.