



Physical Therapy Patient Intake Form

1. Name: _____ Date of Birth: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ Preferred Phone #: _____

Emergency Contact: _____ Relationship: _____

2. Reason for today's visit: _____

3. Inciting injury or trauma?

Yes No

Date of Onset/Injury: _____

4. Is your injury:

Auto Related Work Related Accident Related

5. Have you had surgery for this condition?

Yes No

If yes, date of surgery: _____

6. If yes, describe surgery: _____

7. Any other treatment?

Yes No

8. If yes, describe: _____

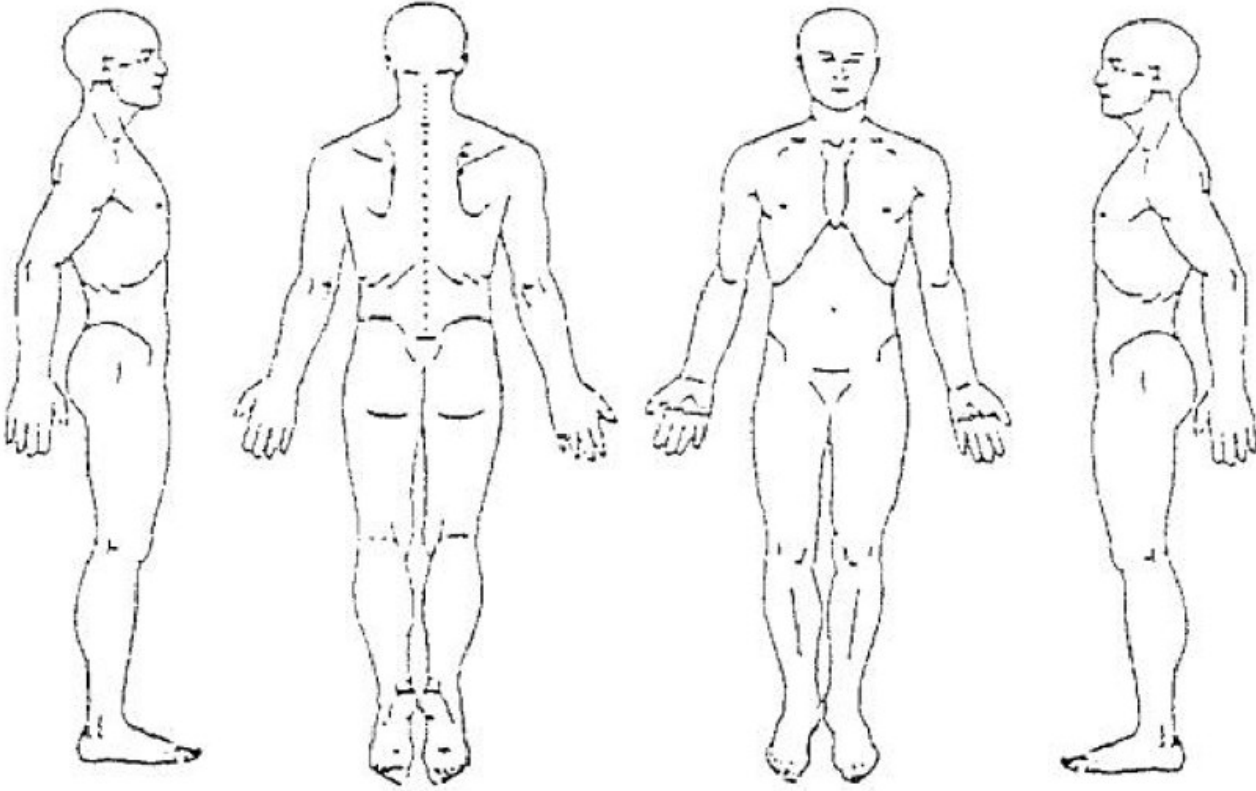
9. Are your symptoms:

- Improved
- Worse
- Stable

10. Please indicate if you have any of these concerns:

- Pain
- Decreased Motion
- Swelling/Edema
- Stiffness
- Loss of Function

11. Please indicate the location of concern:



12. What goal(s) do you have for your physical therapy sessions?

13. How would you rate your physical health?

- Excellent
- Good
- Fair
- Poor

14. Height (ft & in.):

Weight (lbs.):

15. Do you have any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Dizzy/lightheaded | <input type="checkbox"/> Recent Falls |
| <input type="checkbox"/> Discoordination | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Bladder/bowel changes | <input type="checkbox"/> Weight change | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Decreased Mobility | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Implanted Device | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pregnant | | |

16. List any other major medical conditions or injuries you have/had:

17. Past surgeries?

- Yes No

18. If yes, list briefly:

19. Do you have chronic pain?

- Yes No

20. Please Explain (including location and change in mobility):

21. Medication: List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				

22. Any Allergies?

- Yes No

23. If yes, please list:

24. Do you:	Yes	No	Past
Smoke?			
Drink alcohol?			
Use recreational drugs?			

25. If you are employed, are there any physical demands of your job?

- Yes No

26. If yes, please explain:

27. Activity level:

- Sedentary Light Moderate
 Active Extremely Active

28. Do you use any mobility assist devices?

- Yes No

29. If yes, please check all that apply:

- Cane Walker Wheelchair
 Other

If other, specify:
