Physical Therapy

Intake Form

Personal Info:

Name: _____ Birthdate: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip:_____

Cell phone: _____ Email address: _____

Emergency Contact: _____ Cell phone: _____

Personal Medical History:

Do you currently have any of the following conditions (check all that apply):

☑ Surgery (list below)	☐ Diabetes	☐ Asthma	☐ Cardiovascular disease
☐ Circulatory Problems	☐ Migraines	☐ Epilepsy/Seizures	☐ Allergies
☐ Hypermobility	☐ Osteoathritis	☐ High Blood pressure	☐ Stroke/TIA
☐ Concussion	☐ Blood clots	☐ Low Blood pressure	☐ Multiple Sclerosis
☐ Headaches	☐ Cancer/Chemo	☐ Fibromyalgia	☐ Depression/Anxiety
☐ Numbness	☐ Osteoporosis	☐ Rheumatoid Athritis	☐ Pregnancy/Postpartum

Do you have any other medical issue not mentioned above? YES NO
If yes, please specify: _____

Have you had any recent medical procedures/surgery? YES NO
If yes, please specify: _____

Have you had any recent medical imaging? YES NO
If yes, please specify: _____

Physical Therapy *Intake Form*

Client Info

Session Date:_____

Name: _____ Birthdate: _____

Front Back

Please draw in areas of pain using image:

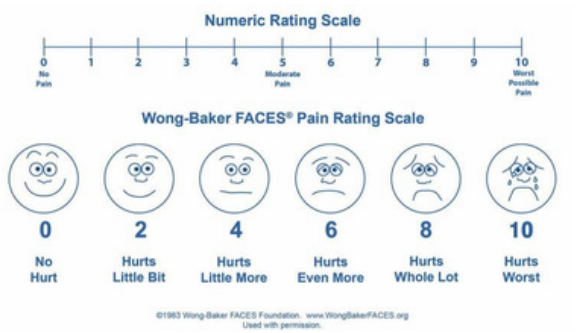
○ pain	hypertonicity	/ elevation
rotation	● tender point	
adhesion	~ trigger point	
= spasm	inflammation	

Description of Pain: _____

_____

_____

Please rate your pain from 0-10 based on scale below:_____



Is there anything that helps or alleviates your symptoms?

_____

_____

_____

Is there anything that makes your symptoms worse (exacerbates)?

_____

_____

How long have you had these symptoms?

_____

_____

_____

Are your symptoms worse/better at certain times of the day?

_____

_____

_____

Physical Therapy *Intake Form*

Client Info

Session Date:_____

Name: _____ Birthdate: _____

Are you currently taking any medication that may affect PT? YES NO

If yes, please list: _____

_____

_____

_____

PT INFORMATION

Have you ever had a physical therapy?	YES	NO
Are you allergic to any oils, lotions, or creams?	YES	NO
Do you find it difficult to lie down on your stomach, back, or side?	YES	NO
Is your skin easily irritated or sensitive?	YES	NO

REASONS FOR SEEKING PHYSICAL THERAPY

Below please list (or check) what you are hoping to achieve through Physical Therapy:

_____

_____

_____

- ☐ I have specific areas of pain or discomfort.
- ☐ I am an athlete and need help with muscle recovery.
- ☐ I want to improve overall health.
- ☐ Injury or post-operative recovery

I completed the above form to the best of my knowledge. I have had the opportunity to ask any questions and have received satisfactory answers. I will inform the therapist of any changes to the above information. I am over the age of 18 and consent to the procedure. If I am under the age of 18, my parent/guardian must sign below. I will not hold the therapist liable for any injury or damage that may occur as a result of the physical therapy or for any issues not disclosed at the time of my service.

Client Signature:_____ **Date:** _____

Parent/Guardian Signature:_____ **Date:** _____
(if under 18)

Client Name:_____ **Date:** _____