Physical Therapy Intake Form

Patient Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)
Ben	Walker	Ben	98484

Gender	Preferred Pronouns	Date of Birth	Marital Status
Male	He/him	23/06/1997	Single

Address	City	State	Zip Code
123 Anywhere St, Suburb	Seattle	WA	1958

Email	Preferred Phone Number
example@email.com	000 0000

Emergency Contact

Full Name	Relationship	Contact Number
Lisa Walker	Mother	000 0000
Allie Walker	Sister	000 0000

Health and Medical Information

Primary Care Physician	Address	Contact Number
Dr R. Ford	5938 Anywhere Ave	000 0000

Reason for visit
Neck and shoulder pain

Rate your current pain on a scale from 1 (least) to 5 (worst)

☐ 1 ☐ 2 ☐ 3 ◉ 4 ☐ 5

Indicate the type of pain you are facing

☑ Sharp ☐ Piercing ☐ Aching ☐ Numbness ☐ Dull ☑ Shooting ☐ Tingling ☐ Stabbing

☐ Other, Please Specify: _____

How often do you experience this pain
When moving shoulder muscles

How often do you exercise
6 days a week, with hockey practices and games as well as runs at the gym

Are your symptoms related to an injury? If so, please describe what happened.
Yes, potentially pulled a muscle at the gym

Patient Information

First Name	Last Name	Date of Birth	Gender
Ben	Walker	23/06/1997	Male

Health and Medical Information (Continued)

List past injuries
Sprained left ankle

List past surgeries
N/a

List any other medical conditions
N/a

List any current medications
Ibuprofen and Paracetemol for pain relief

Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Health4U	Plan B	000 0000
Policy Number	**Group Number**	**Social Security Number**
58329	94837	000 00 0000

Employment Status

☑ Employed ☐ Self-employed ☐ Unemployed ☐ Other, Please Specify: _____

Occupation	Industry	Company Name
Jr Accountant	Accounting	Jones & Co

Company Address	City	State	Zip Code
6948 White Avenue, Anywhere Suburb	Seattle	WA	1958

Availability

Please describe your availability throughout the week
Thursdays 10-12pm, Mon-Friday 5pm onwards

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

Parent or Guardian Name (If Applicable)	Relationship to Patient (If Applicable)
Signature of Patient, Parent or Guardian	Date
	12/12/2022