

# Physical Therapy Intake Form

Patient Information			
First Name	Last Name	Preferred Name	Patient Identifier (If known)
Gender	Preferred Pronouns	Date of Birth	Marital Status
Address		City	State Zip Code
Email		Preferred Phone Number	
Emergency Contact			
Full Name	Relationship	Contact Number	
Full Name	Relationship	Contact Number	
Health and Medical Information			
Primary Care Physician	Address	Contact Number	
Reason for visit			
Rate your current pain on a scale from 1 (least) to 5 (worst) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5			
Indicate the type of pain you are facing <input type="checkbox"/> Sharp <input type="checkbox"/> Piercing <input type="checkbox"/> Aching <input type="checkbox"/> Numbness <input type="checkbox"/> Dull <input type="checkbox"/> Shooting <input type="checkbox"/> Tingling <input type="checkbox"/> Stabbing <input type="checkbox"/> Other, Please Specify: _____			
How often do you experience this pain			
How often do you exercise			
Are your symptoms related to an injury? If so, please describe what happened.			

Patient Information			
First Name	Last Name	Date of Birth	Gender
Health and Medical Information (Continued)			
List past injuries			
List past surgeries			
List any other medical conditions			
List any current medications			
Insurance Information (If Applicable)			
Insurance Carrier	Insurance Plan	Contact Number	
Policy Number	Group Number	Social Security Number	
Employment Status			
<input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Other, Please Specify: _____			
Occupation	Industry	Company Name	
Company Address	City	State	Zip Code
Availability			
Please describe your availability throughout the week			
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	