

Physical Therapy Intake Form

Patient information		
Name:		Date of birth:
Gender:		Contact information:
Address:		
Emergency contact 1		Emergency contact 2
Name:		Name:
Contact information:		Contact information:
Referring MD:		Family MD:
Insurance information		
Insurance provider:		
Policy number:		Group number:
Insurance provider's contact information:		
History		
1. What is your reason for coming to therapy today?		
2. When did your problem begin?		
3. How did your problem start?		
4. Please check the appropriate answer:		
a) Do you have high blood pressure?	Yes	No
b) Do you currently have an infection?	Yes	No
c) Do you have diabetes?	Yes	No
d) Do you currently have heart trouble?	Yes	No
e) Do you have asthma?	Yes	No
f) Do you currently have osteoporosis?	Yes	No

g) Do you currently have active cancer?	Yes	No	
h) Are you pregnant?	Yes	No	NA
i) Do you have other health problems?	Yes	No	
If yes , please list:			
j) Is there anything that your doctor told you not to do?	Yes	No	
If yes , please list:			
k) Are you currently taking any prescription or over-the-counter drugs?	Yes	No	
If yes , please list:			
l) Are you currently taking any herbal preparations / vitamins?	Yes	No	
If yes , please list:			
m) Are you allergic to adhesives/tape, latex, or bee stings?	Yes	No	
If yes , please list:			
n) Have you had any surgeries?	Yes	No	
If yes , please list:			
o) Have you had physical therapy previously for the same problem?	Yes	No	
p) Are you receiving other treatments for this problem at this time?	Yes	No	
If yes , please list:			
q) What kind of tests have been done for your current problem? <i>(check if applicable)</i>			
<input type="checkbox"/> MRI <input type="checkbox"/> X-Ray <input type="checkbox"/> CT Scan <input type="checkbox"/> Myelogram			
Or list:			
Results:			
r) Have you been hospitalized in the past year for this condition?	Yes	No	
If yes , when and for how long?			
s) Does anyone come to your home to provide health care needs (nursing, social work, physical/occupational/respiratory needs)?	Yes	No	
t) Do you have any metallic implants (i.e. pacemaker)?	Yes	No	
If yes , please list:			

Therapist comments:

5. When is your next appointment with the doctor who sent you to us?

6. Pain

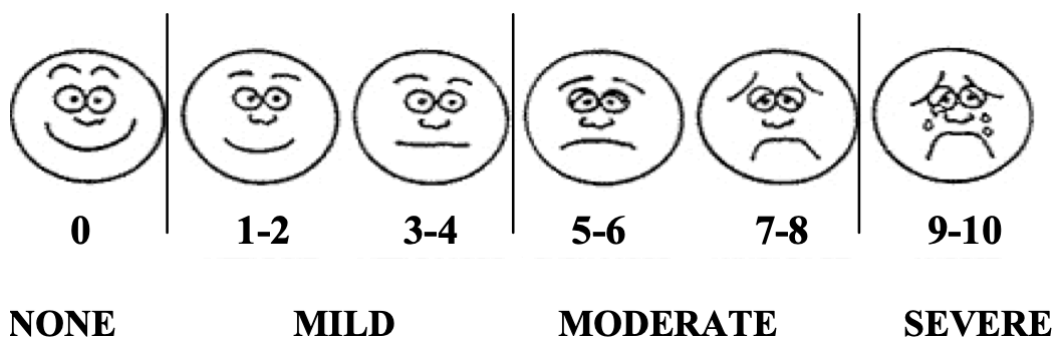
a) Do you have pain now? No Yes, location/type:

b) What makes it better?

c) What makes it worse?

d) Does the pain interfere with your daily life? No Yes, describe:

e) Rate your pain on a scale of 0-10 (0 being no pain and 10 being the worst): _____/10 Today



7. Balance

a) Have you fallen in the last 6 months? Yes No How many times?

b) Have you had a decrease in your activity level because of a fear of falling? Yes No

c) Are you reluctant to leave your home because of a fear of falling? Yes No

d) What are your goals as a result of attending physical therapy?

Please check appropriate box.

☐ Decrease pain

☐ Improve strength

☐ Less difficulty with work activities

☐ Stand longer: _____ minutes / hours.

☐ Improve movement

☐ Sit longer: _____ minutes / hours.

☐ Return to recreational activities / sports activities

☐ Less difficulty with home activities

☐ Sleep longer: _____ hours

☐ Anything else:

Physical therapist signature:

Date: