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)

○ 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

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

◯ Employed ◯ Self-employed ◯ Unemployed ◯ 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