



Physical Therapy Intake Form

Personal Information

Name: _____ DOB: _____ Date: _____

Address: _____ Sex: _____

Phone Number: _____ May we text this number? Yes No

Email Address: _____ Who referred you?: _____

If not applicable, how did you hear about us? _____

Emergency Contact/Relationship: _____ Phone number: _____

History

Exercise Frequency: _____ Exercise Type(s): _____

Please list your sports/hobbies: _____

Are you pregnant? _____ Do you have a pacemaker? _____

Allergies: _____

What medications are you currently taking? _____

Previous surgeries? _____

What body part are we treating today? _____

Do You Have Any of the Following Today? *Circle all that apply*

AIDS/HIV Anemia Arthritis Asthma Blood Clots Bone Infection Cancer

Chemical Dependency Chest Pain Circulation Problems Depression Diabetes Difficulty Breathing

Dizziness Epilepsy Fatigue Frequent Headaches Heart Problems High/Low Blood Pressure

Liver Problems Lung Problems Multiple Sclerosis Sleep Problems Stroke Weight Gain/Loss

