

Physical Therapy Intake Form

Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Who referred you? _____

History

Exercise Frequency: _____ Exercise Type(s): _____
Do you smoke? _____ Have you ever smoked? _____ How Often? _____
Are you pregnant? _____ Do you have a Pacemaker? _____
Allergies: _____
What medications are you currently using? _____
Previous complaints/surgeries: _____
Previous diagnoses/medications: _____

Complaint

What is your major complaint? _____
Start Date: _____ Possible Cause: _____
Symptoms: _____
Previous doctors seen for complaint: _____
Previous treatment for complaint: _____
Symptom-Aggravating Factors: _____
Symptom-Relieving Factors: _____
Time of Day Symptoms are Best: _____ Time They Are Worst: _____
Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating
Is your pain getting better or worse? _____ Have you had this injury before? _____

Do You Have Any of the Following Today? (Check All That Apply)

- | | | | |
|--------------------------------------|--|---|--|
| ☐ AIDS/HIV | ☐ Anemia | ☐ Angina | ☐ Arteriosclerosis |
| ☐ Arthritis | ☐ Asthma | ☐ Blood Clots | ☐ Bone Infection |
| ☐ Cancer | ☐ Chemical Dependency | ☐ Circulation Problems | ☐ Depression |
| ☐ Diabetes | ☐ Epilepsy | ☐ Eye Infection | ☐ Heart Problems |
| ☐ Hemophilia | ☐ High/Low Blood Pressure | ☐ Joint/Bone Infection | ☐ Liver Problems |
| ☐ Lung Issues | ☐ Multiple Sclerosis | ☐ Musculoskeletal Problems | ☐ Pneumonia |
| ☐ Stroke | ☐ STD | ☐ Tuberculosis | ☐ Urinary Infection |

Mark Areas of Discomfort



Signature _____

Date _____