Physical Therapy Intake Form

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

DOB: _____ Sex: M F O_____ Who Referred you?_____

Allergies/Allergic Reactions (describe reactions):_____
_____
_____

Please list current medications: _____
_____
_____

Past Medical History (include all prior diagnoses/complaints/surgeries):_____
_____
_____

Date of Injury: _____ Date of Surgery, if any: _____

Please check whether this problem is: _____Chronic (meaning persisting for a long time or constantly recurring) or

_____ Acute (meaning a rapid onset and occurred recently)

Please describe the problem along with how it happened: _____
_____
_____
_____

What makes the problem feel worse? _____
What makes the problem feel better? _____

Please list treatment(s) you had for this problem (X-Ray, MRI, Injections, Medications, Acupuncture, Therapy OT/PT/SLT, Chiropractic, etc.): _____
_____
_____

Please list any additional information that would assist us in providing care to you or you would like your physical therapist to know about you (occupation, hobbies, activities at home, etc.): _____
_____
_____

Please list expectations/goals for physical therapy: _____
_____
_____

Do you now or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	High Blood Pressure	___	___
Anemia	___	___	Shortness of Breath/Chest Pain	___	___
Heart Attack or Surgery	___	___	Diabetes	___	___
Coronary Heart Disease or Angina	___	___	Thyroid Trouble/Goiter	___	___
Gout	___	___	Cancer/Chemotherapy/Radiation	___	___
Dizziness or Fainting	___	___	Weakness	___	___
Emotional/Psychological Problems	___	___	Infectious Diseases	___	___
Hernia	___	___	Bowel or Bladder Problems	___	___
Numbness or Tingling	___	___	Allergies	___	___
Severe or Frequent Headaches	___	___	Elbow/Hand Injury	___	___
Osteoporosis	___	___	Vision or Hearing Difficulties	___	___
Neck Injury/Surgery	___	___	Stoke/TIA	___	___
Sleeping Problems/Difficulties	___	___	Back Injury/Surgery	___	___
Blood Clot/Emboli	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Knee Injury/Surgery	___	___	Epilepsy/Seizures	___	___
Do you have a Pacemaker	___	___	Arthritis/Swollen Joints	___	___
Varicose Veins	___	___	Pins or Metal Implants	___	___
Are you Pregnant?	___	___	Joint Replacement	___	___
Weight Loss/Energy Loss	___	___	Do you smoke? How often? _____	___	___
Have you ever had COVID	___	___	Have you ever smoked?	___	___
Brain Injury/Surgery	___	___	Transplant	___	___

Emergency contact information (REQUIRED): This person will be contacted as soon as possible in the event that we cannot reach you or there is an emergency. This gives PassionCare Physical Therapy, LLC authorization to discuss my medical condition pertinent to this emergency with your emergency contact and any medical personnel.

Emergency Contact Name:_____ Relationship: _____

Phone Number: (_____)_____

Client / Legal Guardian Signature: _____ Date: _____

Client / Legal Guardian Name: _____

PT Signature: _____ Date:_____

Susan Burdette