

Physical Therapy Intake & Evaluation Form

Please complete this form to help us understand your medical history, current symptoms, and therapy goals. Your information will remain confidential.

Patient Information

Please provide your personal and emergency contact details.

Full Name *

First Name

Last Name

Date of Birth *

Month

Day

Year

Phone Number *

Please enter a valid phone number.

Email Address *

example@example.com

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Occupation

Emergency Contact Name *

Emergency Contact Phone *

Please enter a valid phone number.

Relationship to Emergency Contact *

Reason for Visit / Chief Complaint

Tell us about your main reason for seeking physical therapy.

Briefly describe your main reason for today's visit. *

Which symptoms are you experiencing? (Select all that apply)

- Pain
- Stiffness
- Weakness
- Numbness/Tingling
- Swelling
- Limited Mobility
- Other

How would you describe the status of your symptoms?

- Getting better
- Staying the same
- Getting worse

Describe any activities or movements that worsen your symptoms.

Pain Assessment

Help us understand your pain experience.

Current pain level (0-10)

Best pain level in the past week (0-10)

Worst pain level in the past week (0-10)

Which words best describe your pain? (Select all that apply)

- Sharp
- Dull/Aching
- Burning
- Throbbing
- Constant
- Intermittent
- Other

Does your pain radiate to other areas?

- Yes
- No

If yes, describe where your pain travels.

Functional Limitations

Let us know how your symptoms affect your daily life.

Which activities are difficult for you? (Select all that apply)

- Walking
- Standing
- Sitting
- Climbing stairs
- Lifting
- Bending
- Driving
- Self-care (dressing, bathing, etc.)
- Work-related tasks
- Other

Please describe how your condition is impacting your daily life or activities.

Medical History

Share your relevant medical background.

Are you currently under a physician's care? *

- Yes
- No

If yes, please provide details (physician name, reason, etc.).

Have you had previous physical therapy for this condition? *

- Yes

No

If yes, please describe when and where.

List any surgeries or hospitalizations (include dates if possible).

Do you have any allergies? *

Yes

No

If yes, please list your allergies.

Medical Conditions Screening

Please check any conditions that apply to you.

Please check all current or past conditions:

- Diabetes
- Heart disease
- High blood pressure
- Stroke
- Cancer
- Asthma
- Seizures
- Arthritis

- Osteoporosis
- Depression/Anxiety
- Thyroid problems
- Blood clots
- Other

If you checked any condition above or have others, please describe.

Medications

Let us know about your current medication use.

Are you currently taking any medications? *

- Yes
- No

If yes, please list your current medications (include dosage and frequency if possible).

Imaging & Diagnostics

Share relevant test results, if any.

Please check any imaging or diagnostic tests you have had for this condition:

- X-ray
- MRI
- CT scan
- Ultrasound
- EMG/NCV
- Bone scan

Other

If checked, please describe findings or results.

Therapy Goals

Tell us what you hope to achieve with physical therapy.

What are your goals and desired activities? *

Consent for Treatment

Please review and acknowledge each item below.

I consent to receive physical therapy evaluation and treatment as recommended by my provider. *

I agree

I understand that I may withdraw my consent at any time. *

I acknowledge

Financial & Insurance Acknowledgment

Please review and acknowledge each item below.

I acknowledge that payment/co-pay is due at the time of service. *

I acknowledge

I understand that I am responsible for any charges not covered by my insurance. *

I acknowledge

Signature Section

Please sign and date below to complete your intake.

Printed Name (Patient) *

Date Signed *

Month Day Year