Physical Therapy Patient Intake Form

First Name

Last Name

Date of Birth

Gender

Phone

Email

Address

Emergency Contact Name

Relationship

Phone

Referring Physician

Reason for Visit

When did your symptoms begin?

Have you had physical therapy before?

If yes, when and for what reason?

Medical History (Check all that apply)

- [ ] Diabetes
- [ ] Heart Disease
- [ ] Hypertension
- [ ] Asthma
- [ ] Other

Current Medications

Allergies