# Orthopedic Physical Therapy Initial Consultation Form

## Patient Information

Full Name

Date of Birth

Phone

Email

Address

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## Referral Information

Referred By

Primary Care Physician

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## Injury/Condition Information

Date of Onset/Injury

Location of Problem

Description of Injury/Condition

How has this affected your activities?

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## Pain Assessment

Current Pain Level (0-10)

Character of Pain (sharp, dull, ache, etc.)

Pain Pattern (better/worse with...)

## Medical History

Past Medical Conditions

Current Medications

Allergies

Previous Surgeries

## Functional Status

Work Status

Functional Limitations

Patient Goals