EXPERT MANUAL THERAPY
SUPERIOR CARE, BETTER OUTCOMES

Physical Therapy Brief Intake Form

Brief Physical Therapy Intake

1. Name: ____________________ Date of Birth: __________

Street Address: __________ Apt./Unit #: __________ City: __________ State: ______ Zip Code: ______

Social Security #: __________ Preferred Phone #: __________

Emergency Contact: __________ Relationship: __________

2. **Primary Insurance**

Primary Insurance Company __________ Member ID / Policy # __________ Group Number __________

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name __________ Insured Phone # __________ Insured Date of Birth __________ Insured Gender ○ Female ○ Male

Insured Street Address __________ Insured City __________ Insured State __________ Zip Code __________

3. **Reason for today's visit:**

____

4. **Inciting injury or trauma?**

○ Yes
○ No

Date of Onset/Injury:

____

5. **Is your injury:**

○ Auto Related
○ Accident Related
○ Work Related

6. Have you had surgery for this condition?

- Yes
- No

If yes, date of surgery:

___

7. If yes, describe surgery:

___

8. Any other treatment?

- Yes
- No

9. If yes, describe:

___

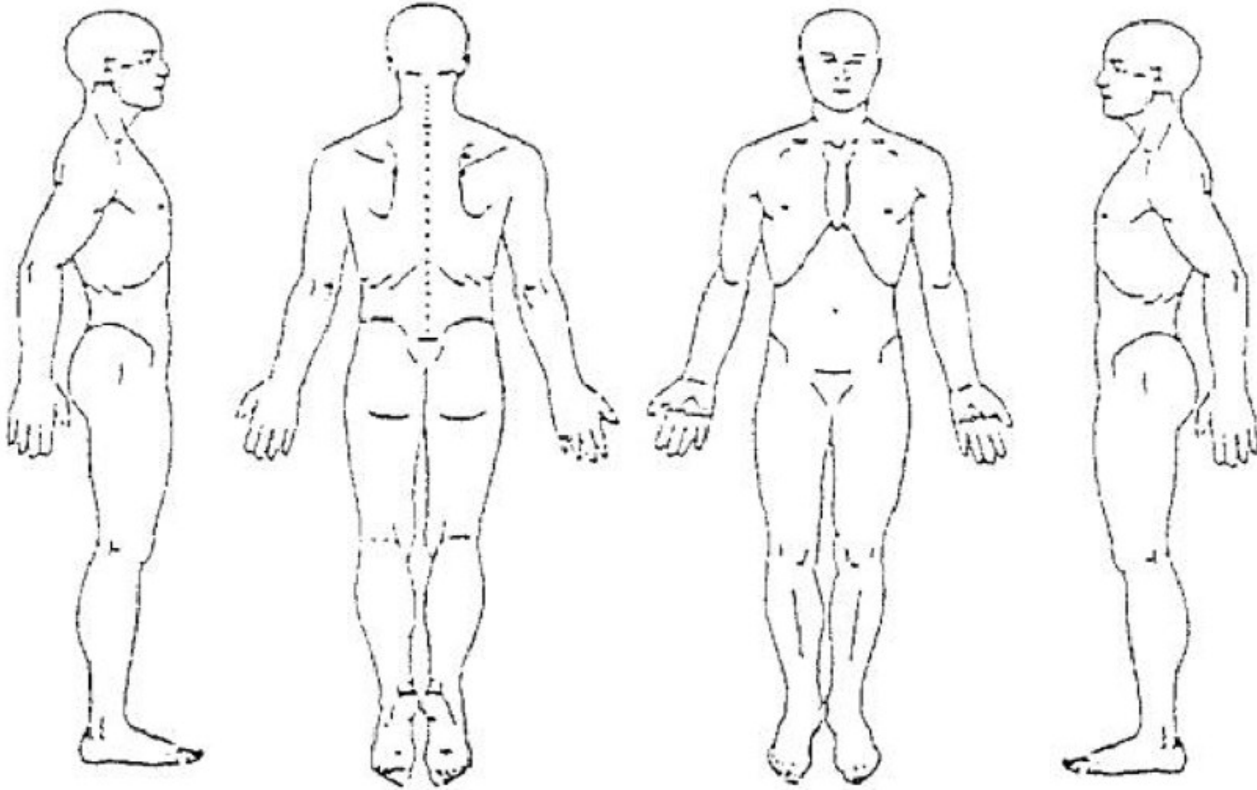
10. Are your symptoms:

- Improved
- Worse
- Stable

11. Please indicate if you have any of these concerns:

- Pain
- Decreased Motion
- Swelling/Edema
- Stiffness
- Loss of Function

12.Please indicate the location of concern:



13. What goal(s) do you have for your physical therapy sessions?

____

____

____

____

14. How would you rate your physical health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

15. Height (ft & in.): ____________________ Weight (lbs.): ____________________

16. Do you have any of the following?

- ☐ Poor Sleep
- ☐ Discoordination
- ☐ Bladder/bowel changes
- ☐ Bleeding problems
- ☐ Seizures
- ☐ Heart Disease
- ☐ Pregnant
- ☐ Dizzy/lightheaded
- ☐ Vision Changes
- ☐ Weight change
- ☐ Decreased Mobility
- ☐ Headaches
- ☐ Implanted Device
- ☐ Recent Falls
- ☐ Hearing Impairment
- ☐ Nausea/vomiting
- ☐ Bleeding problems
- ☐ High Blood Pressure
- ☐ Diabetes

17. List any other major medical conditions or injuries you have/had:

____
____
____
____

18. Past surgeries?

- Yes
- No

19. If yes, list briefly:

____
____
____
____

20. Do you have chronic pain?

- Yes
- No

21. Please Explain (including location and change in mobility):

____
____
____
____

22. Medication: List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				

23. Any Allergies?

- Yes
- No

24. If yes, please list:

____

____

____

____

25.

Do you:	Yes	No	Past
Smoke?			
Drink alcohol?			
Use recreational drugs?			

26. If you are employed, are there any physical demands of your job?

- Yes
- No

27. If yes, please explain:

____

____

____

____

28. Activity level:

- Sedentary
- Light
- Moderate
- Active
- Extremely Active

29. Do you use any mobility assist devices?

- Yes
- No

30. If yes, please check all that apply:

- Cane
- Walker
- Wheelchair
- Other

If other, specify:

____