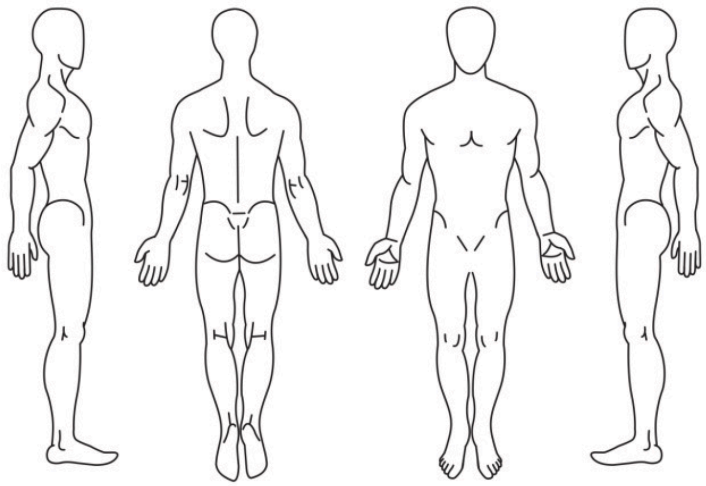
Physical Therapy Intake Form

Primary Area Of Concern (Select One)

☐ Neck, Jaw, Head (may include shoulder/arm/mid-back)
☐ Shoulder or Arm (no neck involvement)
☐ Low Back, Pelvis, Hip (may include mid-back)
☐ Hip or Knee (no low back involvement)
☐ Foot, Ankle, or Calf
☐ None of the above (Such as gait, balance, mobility. Please describe.)

Body Chart



Additional Concern(s)

Please list any accidents, injuries, or surgeries related to this concern.	
Have you had any imaging done of these or other areas (ex. X-ray, MRI, CT, etc.)?	
Rate your AVERAGE pain over the last week.	■ 0 (no pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (emergency room)
Please list any medications or supplements you are CURRENTLY taking.	

Please list ALLERGIES to any medications, foods, or adhesives.	

Activity	
What is your Occupation?	
Which recreational activities or hobbies do you enjoy?	
Describe your activity level or exercise frequency/type.	

Please tell me about your sleeping patterns.	
Number of hours per night	
Number of times you wake per night	
Reason for waking	
☐ Restful ☐ Restless ☐ Side sleeper ☐ Back Sleeper ☐ Stomach sleeper	

Are you currently receiving any of the following therapies?	☐ Massage Therapy ☐ Chiropractic ☐ Physical Therapy ☐ Naturopathic Medicine ☐ Medical Doctor ☐ Other
If so, please indicate the frequency of these treatments and (approx) most recent appointment date	

Musculoskeletal System	☐ Acute muscle and joint pain ☐ Back pain ☐ Spondylolisthesis ☐ Chronic muscle and joint pain ☐ Jaw pain ☐ Tendonisis/Bursitis ☐ Swollen/stiff joints ☐ Rheumatoid arthritis ☐ Scoliosis ☐ Numbness in arms or legs ☐ Osteoarthritis ☐ Artificial joints, pins, or wires
Cardiovascular/Respiratory System	☐ Chest pains ☐ Low blood pressure ☐ Pneumonia ☐ Heart palpitations ☐ Stroke ☐ Emphysema

	☐ Pacemaker ☐ Chronic cough/cold/flu ☐ Anaemia ☐ Heart disease ☐ Shortness of breath ☐ Deep vein thrombosis ☐ Heart attack ☐ Asthma ☐ Varicose veins ☐ High blood pressure ☐ Bronchitis
Digestive System	☐ Painful bowel movements ☐ Increased food sensitivities ☐ Diabetes ☐ Haemorrhoids ☐ Loss/increase in appetite ☐ Gall stones ☐ Chronic bloating ☐ IBS ☐ Hepatitis ☐ Acid reflux ☐ Colitis ☐ Cirrhosis ☐ Hiatal hernia ☐ Constipation ☐ Liver/Gall bladder dysfunctions ☐ Ulcer(s) ☐ Diarrhea ☐ Nausea ☐ Crohn's disease
Nervous System	☐ Paralysis ☐ Numbness/tingling sensation ☐ Balance loss ☐ Epilepsy ☐ Fainting ☐ Degenerative disease
Head/ENT	☐ Headaches/Migraines ☐ Tinnitus/hearing loss or dysfunction ☐ Fatigue/Sleep disorder ☐ Dizziness/Vertigo ☐ Congested sinuses ☐ Chronic laryngitis/pharyngitis/tonsilitis ☐ Loss of vision ☐ Loss of smell/taste ☐ Dental surgery ☐ Earaches ☐ Memory loss
Reproductive/Urinary System	☐ Kidney stones ☐ Urgency ☐ Prostate dysfunction ☐ Kidney failure ☐ Bladder prolapse ☐ Sexual dysfunction ☐ Painful urination ☐ Chronic urinary tract infections ☐ Incontinence ☐ Chronic yeast infections
Immune and Lymphatic System	☐ Edema ☐ Lymphedema ☐ Autoimmune disorder
Integumentary System	☐ Sensitive skin/rashes ☐ Eczema/psoriasis ☐ Acne ☐ Herpes ☐ Parasitic infections ☐ Dermatitis
Mental Health	☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ OCD ☐ Substance abuse ☐ ADD/ADHD
Women's Health	☐ Pain, heaviness, or irregular menstruation ☐ Abortion(s) ☐ Cystic or tender breast tissue ☐ Endometriosis ☐ D & C ☐ Breast feeding
Use this area to elaborate on any checked boxes above	

What are your expectations or goals for receiving treatment?

Out-Of-Network Agreement

☐ I understand that visits with my physical therapist may be out-of-network and payment by cash, check, or charge is expected at the time of the visit. Documentation for bill submission for out-of-network benefits is available upon request.

This template was adapted from a real intake form used by physical therapists on Jane. Customize it to reflect your practice's policies, branding, jurisdiction, and scope of practice.