RehabPT

# New Patient Intake Form

## Patient Information:

**Full Name:**

**Date of Birth:**

**Phone Number:**

**Email:**

**Address:**

**Medical History:**

**Primary Care Physician:**

**Reason for seeking physical therapy:**

**Current medications:**

**Allergies:**

**Previous surgeries or hospitalizations:**

**Current or past injuries:**

## Emergency Contact:

**Name:**

**Relationship:**

**Phone Number:**

## Insurance Information:

**Insurance Provider:**

**Policy Number:**

**Group Number:**

**Primary Insured:**

**Date of Birth of Primary Insured:**

## Current Symptoms:

**Location of pain/discomfort:**

**Duration of symptoms:**

**Severity of symptoms (scale of 1-10):** 10

**Aggravating factors:**

**Easing factors:**

**Impact on daily activities:**

## Functional Goals:

**What would you like to achieve through physical therapy?**

**What activities or movements do you currently have difficulty with?**

**Are there any specific sports or activities you would like to return to?**

**Patient Signature: _____ Date: _____**