The Healing Institute
Physical Therapy New Patient Intake Form

Patient Information
Name: _____
Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F ☐ Other
Address: _____
City: _____ State: _____ Zip: _____
Phone (Cell): _____ (Home): _____
Email: _____
Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Emergency Contact: _____
Relationship: _____ Phone: _____

Primary Care Physician: _____
Phone: _____ Fax (if known): _____

Referral Source
☐ Physician Referral ☐ Self-Referral ☐ Friend/Family ☐ Website ☐ Social Media ☐ Other: _____

Medical History
Have you had physical therapy before? ☐ Yes ☐ No
If yes, for what condition? _____
Surgical History (List surgeries and dates):

Please check if you have or had any of the following conditions: ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease
☐ Stroke ☐ Osteoporosis ☐ Seizures ☐ Depression/Anxiety ☐ Other: _____

List any medications you are currently taking:

Allergies (medications, latex, etc.): _____

Reason for Today's Visit
Describe your current condition/injury:

Date of Onset/Injury: _____ How did it occur? _____
Have you received treatment for this condition? ☐ Yes ☐ No
If yes, describe: _____

Rate your current pain level (0 = no pain, 10 = worst pain):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What are your goals for physical therapy?

Authorization and Consent
☐ I consent to evaluation and treatment by The Healing Institute.
☐ I authorize the release of information to my insurance company and/or physician.
☐ I acknowledge that I have received or reviewed The Healing Institute's Notice of Privacy Practices.

Signature: _____
Date: _____

For Office Use Only
Therapist Initial Evaluation Notes:

Therapist Name: _____ Date: _____