

Patient Information:

Physical Therapy Intake Form

Today's Date _____

First Name _____ Last Name _____

Date of Birth _____ Occupation _____

Address _____

City _____ State _____ Zip _____

Email _____ Cell () _____

Emergency Contact Information:

Name _____ Cell () _____ Relation _____

Medical History:

Reason for seeking therapy: _____

Date of injury or symptom onset _____

Are you currently receiving any other care for the condition mentioned above? Yes ____ No ____

If yes, please list: _____

Please list any previous physical therapy treatments you have received for the above mentioned condition and the results of the treatments (successful or unsuccessful): _____

Have you participated in physical therapy for any other problems/conditions? Yes ____ No ____

If yes, please list: _____

Please list any medications you are taking: _____

Do you have any allergies? Yes ____ No ____ If yes, Please list _____

Please list any medical conditions you have been diagnosed with as well as any previous surgeries you have had:

The above information is accurate to the best of my knowledge.

Patient Signature _____ Date _____

Elevate Physical Therapy LLC
Pamela Bentley, PT, DPT, Cert. AIB-VR, Cert. DN
3570 Old Milton Pkwy
Alpharetta, GA 30005
T: 678-602-5277 F: 678-601-2944