Physical Therapy Intake Form

Today's Date ____________

Patient Information:

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
Practicing Within the Center for Peak Performance
3570 Old Milton Pkwy
Alpharetta, GA 30005
T: 678-879-9019 F: 678-879-9021