Flow Physical Therapy Intake Form

Welcome to Flow Physical Therapy! Please take a few moments to fill out this intake form so we can better understand your needs and provide the best care possible.

Personal Information

Name: _____
Date of Birth: _____

Address: _____
Phone Number: _____
Email Address: _____
Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Emergency Contact

Name: _____
Phone Number: _____
Relationship to Patient: _____

Insurance Information

Primary Insurance Carrier: _____
Policy Number: _____
Group Number: _____
Subscriber Name: _____
Relationship to Subscriber: _____

Medical History

1. **Primary Care Physician's Name:** _____
   Phone Number/Office Location: _____
2. **Height**_____ **Weight**_____
3. **Have you ever had any of the following conditions? (Check all that apply)**

☐ Heart disease
☐ Diabetes
☐ Hypertension
☐ Stroke
☐ Arthritis
☐ Osteoporosis
☐ Neurological disorders (Parkinson's, MS)
☐ Blood clots

☐ Cancer
☐ Asthma/Breathing Issues
☐ Seizures
☐ Other (Please specify): _____

4. **List any surgeries you've had (include dates):**

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4. **Are you currently taking any medications?**
☐ Yes ☐ No
If yes, please list:

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5. **Do you have any allergies (medications, foods, etc.)?**
☐ Yes ☐ No
If yes, please list:

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6. **Do you smoke or Drink?**
☐ Yes ☐ No
If yes, how much? _____

Current Injury/Condition

What brings you to physical therapy? Circle on the picture where you feel pain or symptoms

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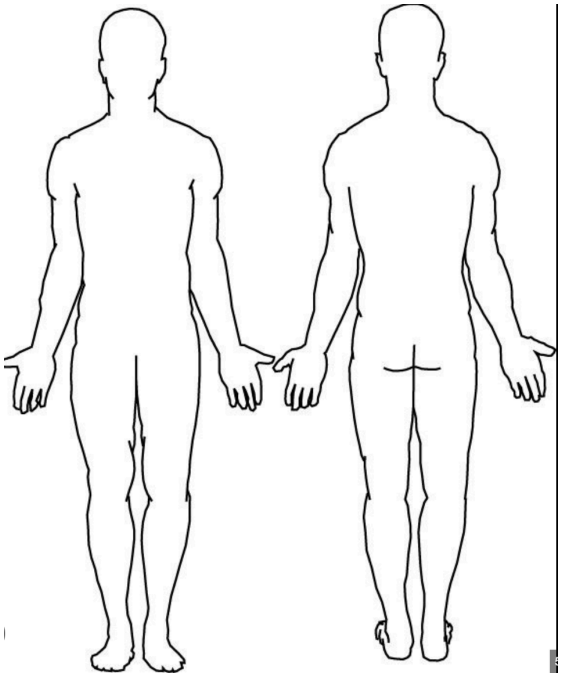

When did you first notice symptoms?
☐ Today ☐ 1-2 days ago ☐ 1-2 weeks ago ☐ Other:
_____

How would you describe the pain? (Check all that apply)
☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Tingling ☐ Stiffness
☐ Other: _____

On a scale of 1-10, how would you rate your pain?
(1 = minimal pain, 10 = worst pain imaginable)
__ / 10

Does the pain get worse with any activities?
☐ Yes ☐ No
If yes, which activities? _____

Does the pain improve with any activities or rest?
☐ Yes ☐ No
If yes, how? _____

Have you had any diagnostic imaging for your injury?
☐ Yes ☐ No
If yes, please attach or list any reports (e.g., X-ray, MRI, CT scan):

Functional Limitations

1. **Does your condition affect your daily activities?**
☐ Yes ☐ No
If yes, how? _____
2. **Does your injury affect your work or sport performance?**
☐ Yes ☐ No
If yes, how? _____
3. **What goals would you like to achieve through physical therapy?**

Lifestyle and Exercise

1. **What is your current level of physical activity?**
☐ Sedentary (little to no exercise)
☐ Lightly active (light exercise or sports 1-3 days/week)
☐ Moderately active (moderate exercise or sports 3-5 days/week)
☐ Very active (hard exercise or sports 6-7 days/week)
2. **What type of exercise do you perform?**

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3. **Do you have any history of injury related to your activities?**
☐ Yes ☐ No
If yes, please describe: _____
4. Occupation:

Signature

I certify that the information provided is accurate to the best of my knowledge. I understand that any changes to my health history or medications should be reported to my physical therapist.

Patient Signature: _____

Date: _____