BACK IN MOTION
PHYSICAL THERAPY

Patient Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Full Name:
_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

SSN #_____

Your Home Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Name of Employer: _____

Work Phone Number: _____
May I leave a message? □ No □ Yes

Home Phone: _____
May I leave a message? □ No □ Yes

Cell/Other Phone: _____
May I leave a message? □ No □ Yes

E-mail: _____ May I email you? □ No □ Yes

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Name of your spouse (if applicable): _____

Spouse phone number (if applicable): _____

Spouse's Employer (if applicable): _____

Spouse's work phone number (if applicable): _____

Emergency Contact Full Name: _____

Relationship to patient: _____

Emergency Contact Phone Number: _____

How did you find out about my services?

_____

Referred By: _____

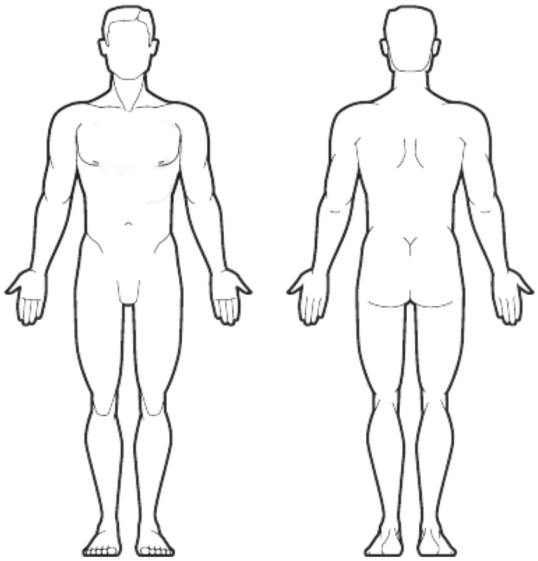
Have you previously received any type of physical therapy services? □ No □ Yes
If yes, please list reason and provide dates:

_____
_____
_____
_____
_____

Surgical History: _____
_____
_____

What are we seeing you for today: _____
_____
_____
_____

Please circle where you are feeling any pain:



Anything else you would like for us to know: _____
_____
_____
_____

_____
Patient Signature

_____
Print Name

_____
Today's Date