

PHYSICAL THERAPY INTAKE FORM

PATIENT INFORMATION

Full Name: _____ Preferred Name: _____ Date of Birth: _____
 Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____
 Cell Phone: _____ Home Phone: _____ Work Phone: _____
 Email Address: _____ Preferred Contact Method: Phone Email Text
 Gender: Male Female Other Pronouns: _____ Marital Status: Single Married Partnered Divorced Widowed
 Occupation: _____ Employer: _____
 Emergency Contact Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____ Group #: _____
 Insured's Name (if different): _____ Date of Birth: _____ Relationship to Patient: _____
 Secondary Insurance: _____ ID #: _____ Group #: _____
 Insured's Name (if different): _____ Date of Birth: _____ Relationship to Patient: _____
 How did you hear about us? Physician Family/Friend Online (Google, Website, Social Media) Insurance Other: _____

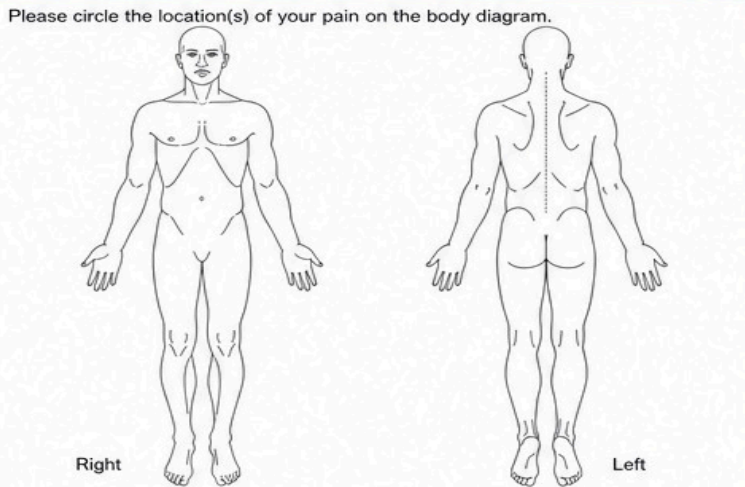
CHIEF COMPLAINT / CURRENT PROBLEM

What is the primary reason you are seeking physical therapy today?

 When did your problem begin? _____ Gradual Onset Sudden Onset Injury Other
 How did it occur? (Mechanism of Injury or Cause)

 Please rate your pain:
 At Best: _____ /10 At Worst: _____ /10 Currently: _____ /10

PAIN / SYMPTOMS



Type of pain: (check all that apply)
 Sharp Dull Aching Throbbing Burning
 Numbness Tingling Stiffness Other: _____
How often do you experience the pain?
 Constantly Frequently Intermittently Occasionally
What makes your pain worse? (Activity, positions, time of day, etc.)

What makes your pain better? (Activity, medication, rest, etc.)

 Do you have pain at night? Yes No
 Does pain interfere with sleep? Yes No
 Do you experience any of the following? (Check all that apply)
 Numbness / Tingling Weakness Clicking / Popping
 Locking / Catching Giving Way Other: _____

FUNCTIONAL LIMITATIONS

What activities are difficult for you?

 Are you working? Yes No
 Job / Occupation: _____
 Work Requirements: Sedentary Light Moderate
 Heavy Very Heavy

GOALS FOR THERAPY

What are your goals / what would you like to be able to do?
 1. _____
 2. _____
 3. _____

PRIOR TREATMENT FOR THIS CONDITION

Have you had any prior treatment for this condition?
 Yes No
 If yes, please check all that apply:
 Physical Therapy Chiropractic Care Injections
 Medication Surgery Other: _____
 When? _____
 Did it help? Yes No Temporarily

PAST MEDICAL HISTORY

Please check all that apply:
 High Blood Pressure Heart Disease Stroke / TIA
 Diabetes Cancer Arthritis
 Osteoporosis Asthma / COPD Kidney Disease
 Depression / Anxiety Thyroid Disorder Pacemaker / Defibrillator
 Blood Clots Seizures / Epilepsy Other: _____
 Please list any other medical conditions not listed above:

PAST SURGICAL HISTORY

Please list all surgeries and approximate dates:

MEDICATIONS & ALLERGIES

Current Medications (name & dose):

 Allergies (medications, latex, tape, etc.):



OUTPATIENT PHYSICAL THERAPY CONSENT FORM

Please read the following information carefully. It is important that you understand the purpose and nature of physical therapy treatment and give your consent to care.

<p>1. NATURE OF PHYSICAL THERAPY SERVICES</p> <p>Physical therapy is a health care service that aims to evaluate, treat, and help prevent impairments, functional limitations, and disabilities related to movement and physical function. Treatment is individually designed to help reduce pain, improve mobility, restore function, and enhance overall quality of life.</p> <p>Treatment may include, but is not limited to, the therapeutic interventions and modalities listed below.</p>	<p>2. BENEFITS AND RISKS</p> <p>The goal of physical therapy is to improve your condition and help you return to your prior level of activity. While physical therapy is generally safe and effective, some risks may be associated with treatment, including but not limited to: muscle soreness, fatigue, dizziness, skin irritation, bruising, or increased pain. Your physical therapist will monitor your response to treatment and modify care as needed.</p>
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3. TREATMENT MODALITIES

Please initial next to each modality to indicate your consent.

PLEASE INITIAL	MODALITY	DESCRIPTION & POTENTIAL RISKS
_____	Therapeutic Exercise	Exercises to improve strength, flexibility, endurance, balance, and overall function. Risks: Muscle soreness, fatigue, temporary increase in pain.
_____	Manual Therapy	Hands-on techniques including joint mobilization/manipulation and soft tissue mobilization to improve movement and reduce pain. Risks: Soreness, temporary discomfort, rare risk of bruising or increased pain.
_____	Dry Needling	Insertion of sterile, single-use filiform needles into myofascial trigger points to help reduce muscle pain, improve mobility, and restore function. Risks: Soreness, minor bleeding, bruising, temporary fatigue, rare risk of infection or nerve irritation.
_____	Electrical Stimulation (E-Stim)	Use of electrical currents to reduce pain, decrease muscle spasm, and/or promote muscle activation. Risks: Skin irritation, discomfort, rare risk of burns.
_____	Ultrasound	Use of sound waves to promote tissue healing, reduce pain, and increase tissue extensibility. Risks: Mild warmth, skin irritation, rare risk of tissue irritation.
_____	Shockwave Therapy	Use of acoustic waves to promote healing in soft tissue conditions such as tendinopathies, plantar fasciitis, and other musculoskeletal disorders. Risks: Soreness, redness, swelling, bruising, temporary increase in pain.
_____	Neuromuscular Re-education	Techniques to improve movement patterns, balance, coordination, and proprioception. Risks: Fatigue, temporary increase in symptoms.
_____	Therapeutic Activities	Functional activities designed to improve daily living skills and overall movement quality. Risks: Muscle soreness, fatigue, temporary increase in pain.
_____	Taping	Application of tape to support muscles and joints, reduce pain, and improve movement. Risks: Skin irritation or allergic reaction.
_____	Other Modalities as Determined Appropriate	May include but not limited to: heat/cold therapy, instrument-assisted soft tissue mobilization, cupping, blood flow restriction training, gait training, and patient education. Risks: Vary depending on the modality used and will be explained as appropriate.

4. PATIENT RESPONSIBILITIES

As a patient, I understand that I am responsible for:

- Providing accurate and complete information about my medical history and current condition.
- Asking questions if I do not understand any part of my care or instructions.
- Following through with recommended treatment and home exercise programs.
- Informing my physical therapist of any changes in my condition.
- Treating staff with respect and communicating openly.

5. RELEASE OF INFORMATION

I authorize Princeton Physical Therapy & Sports Medicine, LLC to communicate with other healthcare providers as necessary for continuity of care.

6. CONSENT FOR TREATMENT

I have read and understand the information above. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I voluntarily consent to receive outpatient physical therapy services from Princeton Physical Therapy & Sports Medicine, LLC.

Patient Name (Printed): _____	Date of Birth: _____
Signature: _____	Date: _____
Parent/Guardian Name (if patient is a minor): _____	_____
Signature of Parent/Guardian: _____	Date: _____





1. PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

2. ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for **Princeton Physical Therapy & Sports Medicine, LLC**.

This notice explains how my medical information may be used and disclosed and how I can access this information.

Patient Initials: _____

3. AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I understand that my health information may be used or disclosed for the following purposes:



Treatment, planning and coordination of care



Payment and billing for services



Healthcare operations (quality improvement, administrative functions)

4. PERMISSION TO COMMUNICATE

Please check all that apply:

Voicemail messages may be left regarding appointments or care

Text messages may be used for appointment reminders

Email communication is acceptable

5. AUTHORIZED INDIVIDUALS (OPTIONAL)

I authorize the following individuals to receive information about my care:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

6. PATIENT RIGHTS

I understand that I have the right to:

- Request restrictions on how my information is used
- Request confidential communication methods
- Access and obtain copies of my medical records
- Request corrections to my medical record

7. CONSENT AND UNDERSTANDING

I understand that:

- My information will not be shared without my permission except as allowed by law
- I may revoke this authorization at any time in writing
- Refusal to sign this form does not prevent me from receiving treatment

8. SIGNATURE

Patient Name (Print): _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

If patient refuses to sign:

Reason: _____

Staff Initials: _____ Date: _____

