Physical Therapy Patient Consultation Form

Please complete this form as accurately as possible. This information will help us design a safe and effective physical therapy program tailored to your needs.

1. Patient Information

Full Name:		Date of Birth:	
Phone Number:		Email Address:	
Street Address:			
Emergency Contact Name:		Emergency Contact Phone:	

2. Medical History & Referral Details

Referring Physician Name:		Next Physician Appointment:	
Primary Diagnosis / Reason for Visit:			
Date of Injury or Onset of Symptoms:		Have you had surgery for this condition? (Yes/No):	
Date of Surgery (if applicable):		List any other medical conditions or active implants:	

3. Symptoms and Pain Assessment

Location of pain or discomfort:			
Current pain level (Rate from 0 to 10, where 10 is worst):		Pain level at its best:	
Pain description (e.g., sharp, dull, aching, throbbing):			
What makes the pain worse? (Aggravating factors):			
What makes the pain better? (Relieving factors):			

4. Functional Limitations & Goals

Activities you cannot perform due to your condition:	
Your personal goals for physical therapy:	

5. Consent and Authorization

By signing below, you consent to receive physical therapy evaluation and treatment as prescribed by your physician or recommended by your physical therapist.

Patient Signature (Print Name to sign):		Date:	
Therapist Signature (Print Name to sign):		Date:	