LIVINGSTONE
PHYSICAL THERAPY

Client Intake Form

Name_____ DOB _____

Email address_____ mobile _____

Home address_____

Body part_____ Date of Injury _____

Occupation _____ Hobbies_____

What is the nature of the current injury?_____
(eg: Work related, chronic/recurring, fall, MVA, recreational, lift or carry, insidious, surgery)

What is your pain rating in the last 24 hours? _____
(0-10 Numeric Pain Rating Scale. 0 is no pain, 10 is worst possible pain)

Where is your pain? _____

My symptoms are made better by_____

My symptoms are made worse by _____

What is your goal with physical therapy? _____
(eg: Related to activities of daily living, sports, hobbies, managing pain)