Inspired Mobility Physical Therapy: Intake Form

Name _____
Contact number _____
Contact email _____

Are you ☐ Right ☐ Left **handed**

Sex ☐ Male ☐ Female **Date of Birth** _____

Past Orthopedic Injury History:

Location of Injury (ie. Knee, Ankle, Shoulder, etc)	Type of Injury (i.e. Sprain, Strain, Fracture, etc.)	Approximate Date(s) of Injury	Treatment(s) Received (i.e. Surgery, PT, Bracing, etc)

Do you have any other past medical history not described above (i.e. Diabetes, Dysplasia, Heart/Vascular Disease, Thyroid Dysfunction)?

_____
_____

Please list any medications or supplements you take on a regular basis

Medication Name	Dosage	Treatment for	Length of use

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Please describe your activity level on a daily/weekly basis: _____

_____

What are your goals for this program? _____

_____