

THERAPIST _____

DATE/TIME _____



PLEASE PRINT AND CONFIRM ALL INFORMATION AND COMPLETE APPLICABLE SECTIONS

PATIENT INFORMATION

Patient Name _____ Referring Physician _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Primary Care Physician _____
Date of Birth _____ Sex _____ Diagnosis _____
Email Address _____ Do you accept text reminders? (Cell#) _____
Emergency Contact _____ Phone _____
Have you had Physical Therapy Before? _____ Where? _____ When? _____ Insurance _____
How did you hear about us? _____
What is your occupation? _____ What time of day is best for appointments? _____

HEALTH INSURANCE INFORMATION

PRIMARY

SECONDARY

Insurance Co. Name _____ Insurance Co. Name _____
ID # _____ ID # _____
Subscriber's Name (If other than self) _____ Subscriber's Name (If other than self) _____
Subscriber's Date of Birth _____ Subscriber's Date of Birth _____
Relationship to patient: Spouse _____ Parent _____ Other _____ Relationship to patient Spouse _____ Parent _____ Other _____

WORKMANS COMPENSATION INFORMATION

Insurance Co. Name _____ Claim # _____
Adjustor _____ Phone _____ Ext _____
Employer at the time of Injury _____ Phone _____
Address _____ City _____ State _____ Zip _____
UR Phone _____ UR Fax _____

AUTOMOBILE INSURANCE INFORMATION

Insurance Co. Name _____ Claim # _____
Adjustor _____ Phone _____ Ext _____
Name of Insured (If other than patient) _____ Relationship _____
PIP Available? Yes No Attorney _____ Attorney's Phone # _____



PAST MEDICAL HISTORY QUESTIONNAIRE

Could you be or are you pregnant? YES NO

Do you now or have you ever had any of the following: (Please Check)

	YES	NO		YES	NO		YES	NO
Arthritis	_____	_____	Metal Implants	_____	_____	Osteoporosis	_____	_____
Cancer/Tumor	_____	_____	High Blood Pressure	_____	_____	Recent Weight Loss/Gain	_____	_____
Heart Disease	_____	_____	Current Infection (s)	_____	_____	Heart Attack	_____	_____
Tuberculosis	_____	_____	Pacemaker	_____	_____	Hepatitis	_____	_____
Vascular Disease	_____	_____	Thyroid Problem	_____	_____	Stroke	_____	_____
Headaches	_____	_____	Asthma	_____	_____	Head Injury/Concussion	_____	_____
Shortness of Breath	_____	_____	Hernia	_____	_____	Chronic Cough	_____	_____
Kidney/Bladder Problems	_____	_____	Fainting Spells	_____	_____	Previous Fractures	_____	_____
Diabetes	_____	_____	Previous Surgeries	_____	_____	Anemia	_____	_____
Hearing Loss	_____	_____	Sensitivity to Heat/Cold	_____	_____	Depression	_____	_____
Anxiety	_____	_____	Swelling in Ankles	_____	_____	Substance Abuse	_____	_____
Seizures/Epilepsy	_____	_____	Allergies	_____	_____	Deep Vein Thrombosis	_____	_____
Other, please explain	_____							

If you answered “YES” to any of the above, please explain and give approximate date (s):

Are you presently taking any medications? If “YES”, list all medications:

The information above is correct to the best of my knowledge.

Patient/Parent/Guardian Signature

Date