physical therapy
occupational therapy
...with a smile:)

COMPREHENSIVE PHYSICAL THERAPY

PATIENT INFORMATION

□ New Patient □ Return Patient Email: ______________________

Patient Name: ______________________

Address: ______________________
Street # or PO Box City State Zip Code

Date of Birth: __________ Age: ____ □ Male □ Female SS#: __________

Home Phone: __________ Work or Cell Phone: __________

Patient Status: □ Single □ Married □ Widowed □ Other

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES FOR ANY REASON? □ YES □ NO
IS THIS INJURY THE RESULT OF A WORK RELATED ACCIDENT?: □ YES □ NO
IS THIS INJURY THE RESULT OF AN AUTO RELATED ACCIDENT?: □ YES □ NO

HOW DID YOU HEAR ABOUT US?

□ Newspaper □ Past Patient/Friend □ Medical Doctor □ Website
□ Yellow Pages □Other ______________________

DOCTOR/EMERGENCY CONTACT INFORMATION: (required)

Referring Physician: __________ Primary Care Physician: __________

Date Last Seen: __________ Date Last Seen: __________

Emergency Contact: ______________________

Relationship: __________ Phone Number: __________

PRIVATE INSURANCE/FINANCIAL RESPONSIBILITY INFORMATION: (required)

Person Financially Responsible: __________ Phone: __________

Address: ______________________

Relationship to Patient: ______________________

Primary Insurance: __________ **Secondary Insurance:** __________

Policy#: __________ Policy #: __________

Group #: __________ Group #: __________

Is the Patient the Subscriber? □ Yes □ No **Is the Patient the Subscriber?: □ Yes □ No**

IF NO PLEASE COMPLETE SECTION BELOW

Subscriber Name: __________ **Subscriber Name:** __________

SS#: __________ SS#: __________

ILLNESS OR ONSET OF PAIN INFORMATION: (required)

Relationship to Patient: __________ Relationship to Patient: __________

-CONTINUED-
PLEASE COMPLETE SECOND PAGE

□ ILLNESS □ INJURY Date of Injury/Onset of Symptoms: ______________________________

What body part is involved: ____ □ Left □ Right

Injury Occurred: □ Home □ Employment* □ School* □ Recreation* □ Pedestrian* □ MVA/Auto*

□ Other – Briefly explain: ____

***If this is a Workers Comp/Liability/Auto Claim - Please Complete Section Below**

Name of Workers Compensation/Liability/Auto Insurance: ____

State that incident occurred in: ________________________ Claim #: ___________________________________

Insurance Adjusters Name: ____

Phone Number: __________________________________ Extension Number: ____________________________

Has an Attorney been obtained: □ Yes □ No – If yes please complete below

Attorney Name: ____ Phone: ___________________________

ADDITIONAL INFORMATION: (required)

Employer: ____ Phone: ______________________ □ Retired

Address: ____ Job Description: ___________________________

Are you a student? □ Yes □ No □ Full Time □ Part Time

MEDICAL HISTORY

Please check any medical conditions that we should be aware of:

____ High Blood Pressure	____ Scoliosis/Back Disorder	____ Heart Attack/Heart Problems
____ Diabetes	____ Lung Disorders	____ Blood Disorders
____ Cancer	____ Ulcer/Digestive	____ Arthritis
____ Metal Implants	____ Pacemaker	____ Seizure Disorder
____ Hepatitis C	____ Tuberculosis	____ Vertigo

Are you Pregnant? □ yes □ no

Any Other Conditions/Concerns that we should be aware of?: ____

____

Surgeries and Surgical Dates: ____

____

Medication List Attached: Please complete

ALLERGIES: ____

____

Have you had any diagnostic testing performed related to your current injury?

□ MRI □ X-ray □ CT Scan □ EMG □ None □ Other: ______________________________________

To the best of my knowledge, the information that I have given is complete and true.

Patient/Guardian Signature: ____ **Date:** ______________

Therapist Signature: ____ **Date:** ______________