

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE () _____ MALE ___ FEMALE ___ SOCIAL # _____

CELL PHONE () _____

EMPLOYER: _____ PHONE () _____

ADDRESS: _____

SPOUSE'S NAME: _____ SOC. SEC.# _____

WHO DO WE CONTACT IN CASE OF EMERGENCY? (OTHER THAN YOUR OWN HOME)

NAME: _____ RELATION: _____ PHONE () _____

DR. WHO PRESCRIBED PHYSICAL THERAPY; _____

PRIMARY CARE PHYSICIAN: _____

HAVE YOU HAD ANY PRIOR PHYSICAL THERAPY OR CHIROPRACTIC CARE THIS
CALENDER YEAR? _____ (IF YES, HOW MANY TREATMENTS?) _____

*** IMPORTANT:** Medicare Patients Only- Have you had any home health
nurses or aides come to your home in the past year.

YES _____ **NO** _____

IF***WORKERS COMPENSATION*** DATE OF ACCIDENT _____

EMPLOYER AT TIME OF INJURY _____

EMPLOYER'S INSURANCE CARRIER _____

REPRESENTATIVE _____ PHONE# _____

CLAIM # _____

IF***AUTO ACCIDENT*** DATE OF ACCIDENT: _____

INSURANCE CARRIER _____

REPRESENTATIVE _____ PHONE# _____

CLAIM # _____

ATTORNEY _____ PHONE () _____