

COMPREHENSIVE PHYSICAL THERAPY PATIENT INFORMATION

□ New Patient □ Return Patient	Email:						
Patient Name:							
Address: Street # or PO Box							
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 Wi	idowed Other						
ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES FOR ANY REASON? STATEMENT OF A WORK RELATED ACCIDENT?: STATEMENT OF AN AUTO RELATED ACCIDENT?: STATEMENT OF AUTO RELATED ACCIDENT?: STATEMENT OF AUTO RELATED ACCIDENT?: STATEMENT OF AUTO RELATED ACCIDENT OF AUTOR RELATED AUTOR RELATED ACCIDENT OF A							
HOW DID YOU HEAR ABOUT US? Newspaper							
DOCTOR/EMERGENCY CONTACT INFORMATION: (required)							
Referring Physician:	Primary Care Physicia	Primary Care Physician:					
Date Last Seen:	Date Last Seen:	Date Last Seen:					
Emergency Contact:							
Relationship:	Phone Number:						
PRIVATE INSURANCE/FINANCIAL RESPONSIBILITY INFORMATION: (required)							
erson Financially Responsible: Phone:							
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Relationship to Patient:							
Primary Insurance:	Secondary Insurance:	Secondary Insurance:					
Policy#:							
Group #:							
Is the Patient the Subscriber? \Box Yes \Box No	Is the Patient the Subsc	Is the Patient the Subscriber?: □ Yes □ No					
IF NO PLEAS	SE COMPLETE SECTION BELO	W					
Subscriber Name:	Subscriber Name:	Subscriber Name:					
SS#:	SS#:						
ILLNESS OR ONSET OF PAIN INFORMATION: (required) Relationship to Patient: Relationship to Patient:							
-CONTINUED-							

PLEASE COMPLETE SECOND PAGE

4/29/13

□ ILLNESS □ INJURY	Date of Injury/On	set of Symptoms:				
What body part is involved: _			□ Left □ Rig	ht		
Injury Occurred: Other Br						
□ Other − Briefly explain: *If this is a Workers Comp/Liability/Auto Claim - Please Complete Section Below						
	(T. 1.11)					
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 INFORMATIO						
Employer:		Phone: Retired				
Address:		_ Job Description	:			
Are you a student?	□ Yes □ No	□ Full Time	□ Part Time			
MEDICAL HISTORY						
Please check any medical cor	nditions that we should be	nware of:				
High Blood Pressure	Scoliosis/Back Disc	order	Heart Attack/Hear	rt Problems		
Diabetes	Lung 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: P	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, th	ne information that I have giv	en is complete and tr	rue.			
Patient/Guardian Signature: Date:						
Therapist Signature:			Date	e:		