PATIENT INTAKE/DEMOGRAPHIC INFORMATION

Name: ____ Male/Female

Address: ____

City: ______________________ State: __________ Zip: ______________

Home Phone: ________________ Work: ________________ Cell/Pager: ________________

S.S. #: ______________________ Date of birth: ________________

How did you hear about us?: ____

Employer: ______________________________

Address: ______________________________

City: ________________ State: ________ Zip: ___________

Area of injury: ______________________________ Date of injury: ______________

Referring doctor: ______________________________ Phone: ________________

Primary care physician: ______________________________ Phone: ________________

Have you had any prior physical theray? Y/N If yes, how many visits______________________

Primary insurance: ______________________________ Phone: ________________

Policy holder: ______________________________ Relationship to patient: ______________

Policy #: ______________________________ Group #: ______________________________

Secondary insurance: ______________________________ Phone: ________________

Policy holder: ______________________________ Relationship to patient: ________________

Policy#: ______________________________ Group #: ______________________________

Is your injury related to work _____ or auto accident ______ ?? If yes……

Insurance carrier name: ______________________________ Claim #: ______________________

Phone: ______________________________ Adjuster: ______________________________

Attorney: ______________________________ Phone: ______________________________

Date of evaluation: __________Time: __________ Office: ______________ Therapist: ______________