Physical Therapy Patient Information

Today's Date: ___/___/___

Patient Name: _____ Sex: _____ DOB: ___/___/___

If minor, Name of Parent or Legal Guardian: _____

Name of Insured (*if not patient*): _____ Relationship: _____

Phone: _____ DOB: ___/___/___

Patient Address: _____ Height: _____ Weight: _____

City, State, Zip: _____ Soc. Sec. #: _____-_____-_____.

Phone (home): _____ Work: _____ Cell: _____

Mar.Status: _____ Occupation: _____ Employer: _____

Current Work Status: ☐ FT ☐ PT ☐ Restricted Duty ☐Out of Work (since?_____)

Emergency Contact: _____ Phone: _____

Primary Care Physician? _____ Complaint/injury: _____

Have you had physical therapy for any reason this year? YES NO

If yes, please explain: _____

How did you hear about us? _____

ACCIDENT INFORMATION (please check on of the following)

1. Were you injured while at work? _____ Date of injury: ___/___/___
   Have you received prior treatment? _____ If yes, name of physician: _____
   Workman's Compensation Insurance Agent: _____
   Phone number: _____ Claim #: _____
   Name of Attorney (if applicable): _____ Phone: _____
   Address:_____
   Dates out of Work: From: ___/___/___ To: ___/___/___

   *****If this injury occurred at work, be sure to fill out employer info above*****

2. Automobile accident? _____ Date of accident: ___/___/___
   Have you received prior treatment? _____ If yes, name of physician: _____
   Automobile Insurance Carrier: _____
   Name of adjuster: _____ Phone: _____
   Name of attorney (if applicable): _____ Phone: _____
   Address: _____
   State accident occurred in? _____ Who was at fault? _____
   Dates out of work: From: ___/___/___ To: ___/___/___

PLEASE PROVIDE ALL INFORMATION REGARDING YOUR INSURANCE COVERAGE, ESPECIALLY IF YOU ARE COVERED BY MORE THEN ONE POLICY.