PATIENT INFORMATION

FIRST NAME:_____ TODAY'S DATE: _____/_____/____
LAST NAME:_____ MALE:_____ FEMALE:_____
STREET ADDRESS:_____ BIRTH DATE:_____/_____/_____
CITY, STATE, ZIP:_____ SOCIAL SEC. #:_____
HOME PHONE:_____ MARITAL STATUS: M __ S __ O__
CELL PHONE:_____

HAVE YOU HAD ANY PHYSICAL THERAPY TREATMENT THIS YEAR? **Y N** HOW MANY?_____
HAVE YOU HAD ANY CHIROPRACTIC TREATMENT THIS YEAR? **Y N** HOW MANY?_____

NAME OF THE PHYSICIAN WHO REFERRED YOU TO PHYSICAL THERAPY:_____
NEXT APPOINTMENT WITH THE PHYSICIAN WHO REFERRED YOU:_____
NAME OF PRIMARY CARE PHYSICIAN:_____
DID INJURY OCCUR AT WORK? **Y N**
DID INJURY OCCUR IN AUTO ACCIDENT? **Y N**
STATE ACCIDENT OCCURRED:_____ DATE OCCURRED:_____/_____/_____

EMPLOYMENT INFORMATION

EMPLOYER NAME:_____ OCCUPATION:_____
EMPLOYER ADDRESS:_____ WORK PHONE:_____
CITY, STATE, ZIP:_____

RESPONSIBLE PARTY

(if other than above)

NAME:_____
ADDRESS:_____
SOCIAL SEC. #:_____ DATE OF BIRTH:_____/_____/_____
DAYTIME PHONE:_____ EVENING PHONE:_____
PLACE OF EMPLOYMENT:_____

INSURANCE INFORMATION

(SKIP TO NEXT SECTION IF COPY OF CARD TAKEN)

COPIES OF CARDS? Y N SECONDARY INS? Y N WE DO NOT BILL THIRD PARTY INSURANCES

INSURANCE COMPANY:_____ INSURANCE PHONE:_____
INSURANCE ADDRESS:_____
INSURED'S NAME:_____ INSURED'S ID #:_____
INSURED'S ADDRESS:_____
INSURED'S DATE OF BIRTH:_____/_____/_____