WELCOME TO PROFESSIONAL PHYSICAL THERAPY & SPORTS MEDICINE

PATIENT INFORMATION – Please print clearly and use legal/Insurance names

Last name of Patient_____ First Name_____

Address_____ City_____ St_____ Zip Code_____

Home #_____ Cell #_____ Work #_____

Birth date_____ /_____ /_____ (MM/DD/YYYY) Age_____ Male / Female – Married / Single

E-mail Address_____ Social Security #_____ - _____ - _____

Employer_____ Occupation_____

Date of Injury _____ /_____ /_____ Date of Surgery (If Applicable) _____ /_____ / _____

Referring Physician _____ Primary Physician _____
Have you had Home Health Physical Therapy recently? Yes / No
Have you been to another Physical Therapy office? Yes / No Facility Name: _____
How and where were you injured? _____
What is your biggest complaint? _____
What increases your pain? _____
What decreases your pain? _____
What medications are you currently taking? _____
How did you hear about us? _____
Rating your pain on a scale of 1 to 10 with 10 being the most painful, circle where your pain is:

0 1 2 3 4 5 6 7 8 9 10

RESPONSIBLE PARTY INFORMATION (PARENT OR GUARDIAN) if patient is under 18

Last Name _____ First Name _____

Address _____ City _____ St _____ Zip Code _____

Home # _____ Cell # _____ Work # _____

Birth Date _____ / _____ / _____ Social Security # _____ / _____ /_____ Employer _____

Insurance Company _____How are you related to the Patient? _____

PRIMARY INSURANCE HOLDER INFORMATION (IF DIFFERENT FROM ABOVE)

Policy holder's name _____ Birth date _____ / _____ / _____ SS#_____ / _____ / _____
Home#_____ Employer_____ Insurance Co _____
How are you related to the patient? _____

SECONDARY INSURANCE HOLDER INFORMATION (IF DIFFERENT FROM ABOVE)

Policy holder's name_____ Birth date _____ / _____ /_____ SS#_____ / _____ / _____
Home# _____ Employer _____ Insurance Co _____
How are you related to the patient? _____