

Patient Information

| | | | | |
|------------------|-----|---|--|----------------|
| Last Name/Suffix | | First Name | | Middle Initial |
| Address: | | City | State: | Zip Code: |
| Home Phone | | Other Phone (Cell) | | Email Address: |
| Date of Birth | SSN | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown | |

Employer Information

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|-------------------|--|--|--|--|
| Employer Name: | | Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student | | |
| Work Phone Number | | Patient Occupation | | |

Primary Insurance Carrier / Policy Holder Information

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|------------------------------|-------------------|---|---|---|
| Primary Insurance: | | Insurance Identification Number: | | |
| Policy Holder Name: | | Is policy holder a RETIRED Federal Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other |
| Policy Holder Date of Birth: | Policy Holder SSN | | Policy Holder Address: | |
| Policy Holder Home Phone: | | Employer / Employer Address: | | |

Secondary Insurance Carrier / Policy Holder Information

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|------------------------------|-------------------|---|---|--|
| Secondary Insurance: | | Insurance Identification Number: | | |
| Policy Holder Name: | | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other | |
| Policy Holder Date of Birth: | Policy Holder SSN | | Policy Holder Address: | |
| Policy Holder Home Phone: | | Employer / Employer Address: | | |

Physician Information

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|------------------------------|---------------------------------|
| Name of Referring Physician: | Name of Primary Care Physician: |
|------------------------------|---------------------------------|

Emergency Contact Information

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|---------------|----------|---|--|--|
| Contact Name: | Phone #: | Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Other | | |
|---------------|----------|---|--|--|

Additional Questions

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|---|---|--|---------------------|--|
| Date of Injury / Onset Date | Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Auto-State? _____ <input type="checkbox"/> PI | Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No | Diagnosis/Body Part | |
| Post Surgical: <input type="checkbox"/> Yes / <input type="checkbox"/> No / <input type="checkbox"/> Unknown Surgery Date (if applicable): _____ | | Surgery Description: _____ | | |
| Have you had any prior Therapy this year? <input type="checkbox"/> Yes <input type="checkbox"/> No (PT/OT/SP or Chiropractic) | | How did you hear about us? | | |

I understand that if any changes are made to my personal or insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner

| | | |
|---|-------|--|
| Appointment Date: | Time: | Therapist: |
| Intake Completed By: _____ Date: _____ | | I, acknowledge that the above information is correct Patient/Guardian _____ Date: _____ |