

PATIENT INTAKE: PLEASE PRINT CLEARLY

DATE: _____ / _____ / _____ TREATING THERAPIST: _____

FIRST NAME: _____ LAST: _____ MI: _____

EMAIL ADDRESS: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ GENDER: MALE FEMALE

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ BIRTH DATE: _____ / _____ / _____

S.S.#: _____ - _____ - _____ MARITAL STATUS: _____

REFERRING PHYSICIAN: _____ PHONE: _____

FAMILY PHYSICIAN: _____ PHONE: _____

IN CASE OF AN EMERGENCY CONTACT: _____

HOME PHONE: _____ WORK PHONE: _____

DO YOU HAVE AN ATTORNEY: YES NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF ATTORNEY: _____ PHONE: _____

CURRENT EMPLOYER INFORMATION: ALL INFORMATION MUST BE COMPLETED

EMPLOYER: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PERSON: _____ PHONE NUMBER: _____

ARE YOU PRESENTLY OUT OF WORK AS A RESULT OF THIS INJURY? YES NO

WHEN ARE YOU AVAILABLE FOR TREATMENTS: AM PM

HAVE YOU EVER TREATED AT DYNAMIC P.T. BEFORE: YES NO

IF SO, WHEN DID YOU TREAT: _____ / _____ / _____

INSURANCE INFORMATION:

PLEASE PRINT CLEARLY

WORKERS COMPENSATION: ALL INFORMATION MUST BE COMPLETED

DATE OF INJURY: _____ / _____ / _____

EMPLOYER AT TIME OF INJURY: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PERSON: _____ PHONE NUMBER: _____

INSURANCE CARRIER: _____

P.O. BOX: _____ SUITE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CLAIM REP: _____ PHONE NUMBER: _____

CLAIM NUMBER: _____

DO YOU HAVE A REHAB NURSE: YES NO

NAME: _____ PHONE NUMBER: _____

MAY WE SEND INFORMATION TO YOUR EMPLOYER? YES NO

AUTO ACCIDENT: ALL INFORMATION MUST BE COMPLETED

DATE OF INJURY: _____ / _____ / _____

INSURANCE COMPANY: _____

P.O.
BOX: _____ SUITE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY HOLDER: _____ D.O.B.: _____ / _____ / _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY NUMBER: _____ CLAIM NUMBER: _____

CLAIM REP: _____ PHONE NUMBER: _____

VERIFIED BY: _____

SPOKE TO: _____ TIME: _____

DATE: _____ / _____ / _____

PERSONAL INSURANCE:

PLEASE PRINT CLEARLY

PRIMARY INSURANCE:

IF NONE, PLEASE INITIAL HERE: _____

ALL INFORMATION MUST BE COMPLETED:

POLICY HOLDER: _____ D.O.B.: _____ / _____ / _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE CARRIER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

CLAIM REP: _____ PHONE NUMBER: _____

SECONDARY INSURANCE:

IF NONE, PLEASE INITIAL HERE: _____

ALL INFORMATION MUST BE COMPLETED:

POLICY HOLDER: _____ D.O.B.: _____ / _____ / _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE CARRIER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

CLAIM REP: _____ PHONE NUMBER: _____

VERIFIED BY: _____

SPOKE TO: _____ TIME: _____

DATE: _____ / _____ / _____

TO ASSIST YOUR THERAPIST, PLEASE COMPLETE THE FOLLOWING INFORMATION:

PLEASE CHECK IF YOU HAVE EVER HAD:

ALLERGIES

ARTHRITIS

BLOOD DISORDERS

BROKEN BONES/FRACTURES

CANCER

CIRCULATION/VASCULAR PROBLEMS

DIABETES/HIGH BLOOD SUGAR

HEAD INJURY

HEART PROBLEMS

INCONTINENCE

PACEMAKER

HIGH BLOOD PRESSURE/HYPER-TENSION

INFECTIOUS DISEASE (TUBERCULOSIS, HEPATITIS, ETC.)

KIDNEY PROBLEMS

MULTIPLE SCLEROSIS

MUSCULAR DYSTROPHY

PARKINSONS DISEASE

REPEATED INFECTIONS

SEIZURES/EPILEPSY

SKIN DISEASE/CONDITION

STROKE/CVA/TIA

THYROID PROBLEM

ULCERS/STOMACH PROBLEMS

ARE YOU PREGNANT?

OTHER