Intake Form

DEMOGRAPHICS:

Name (First)__________________(Middle)________________(Last)_________________

Gender (Male/Female-*circle one*) **Date of Birth**__________________________________

Address____

Phone #_________________(Cell/Work/Home-circle one) **Email**____________________

Occupation____________________________**Employer**____________________________

INSURANCE:

Company Name______________________________**Type** (PPO/HMO/Other-*circle one*)

Member/Subscriber ID #___________________________**Group #**__________________

PHYSICAL THERAPY:

Reason for Seeking Treatment____

Involved Body Part(s)_____________________**Date of Onset**____________________

Have you Previously had PT for this Issue (Yes/No-*circle one*) **When**______________

MEDICAL HISTORY:

Please List any injuries, illness, diseases, conditions, or health issues you have or have had____

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Medications____

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