

PATIENT INFORMATION

Therapist/Date _____

Chart # _____

_____	_____	_____	_____	_____
Last Name	First Name	M.I.	Date of Birth	Social Security #
_____	_____	_____	_____	_____
Mailing Address	City	State	Zip	Home Telephone
_____	_____	_____	_____	_____
Employer	Occupation	Work or Cell. Telephone		
_____	_____	_____		
Person to contact in Emergency	Relationship to Patient	Daytime Phone		
_____	_____	_____		

POLICYHOLDER/INSURED INFORMATION ___ Check here if the same

_____	_____	_____	_____	_____
Name of Policyholder/Insured	Date of Birth	Social Security #	Relationship to Patient	
_____	_____	_____	_____	
Mailing Address	City	State	Zip	Home Telephone
_____	_____	_____	_____	_____
Employer	Occupation	Work Telephone		
_____	_____	_____		

PAYOR INFORMATION ___ Check here if the same

_____	_____	_____	_____	_____
Party Responsible for Payment	Date of Birth	Social Security #	Relationship to Patient	
_____	_____	_____	_____	
Mailing Address	City	State	Zip	Home Telephone
_____	_____	_____	_____	_____
Employer	Occupation	Work Telephone		
_____	_____	_____		

MEDICAL INFORMATION

_____	_____	_____	_____
Diagnosis			Date of Onset/Injury
_____	_____	_____	_____
Cause of Injury	Related To:	Work	Auto
_____	_____	_____	_____
Referring Physician	Telephone #	Primary Care Physician	Telephone #
_____	_____	_____	_____

Past Surgeries _____

MEDICAL PROBLEMS: *Please check all those, which apply*

Diabetes _____	Skin _____	Kidney _____	Throat _____
Arthritis _____	Genital/Pelvis _____	Bleeding Problems _____	Mouth _____
Heart/Vascular _____	Vision _____	High Blood Pressure _____	Allergies _____
Abdominal _____	Hearing _____	Urinary _____	Asthma _____
Breathing Problems _____	Seizures _____	Cancer _____	Stomach Problems _____
Hepatitis B _____	Headaches _____	Nose _____	

- Are you allergic to Penicillin? Yes ___ No ___ Have you ever had a reaction to Penicillin? Yes ___ No ___
- Are you allergic to any other drug? Yes ___ No ___ *If so, please list:* _____
- Are you currently taking any medication? *Please list:* _____
- Do you have any food allergies? Yes ___ No ___ *If so, please list:* _____
- Female Patients: Are you Pregnant? Yes ___ No ___ Is there a possibility you are Pregnant? Yes ___ No ___
- In the event of an emergency, which hospital would you prefer to go to? _____