

Date: 1/15/2010

General Information

Name:		Phone:
Account #:	SSN:	Age:
Address:		DOB:
Employer:		Empl. Phone:
Employers Address:		Occupation:
Attorney:		Atty. Phone:
Gender: M / F	Marital Status: S / M / Other	E-mail Address:

Guarantor/Policy Holder Information

Guarantor Name:		Phone #:
Guarantor Address:		
Guarantor Employer:	Guarantor SSN#	Guarantor DOB:
Emergency Contact:	Emergency Phone: Primary#:	Work#:

Injury Information

Date of Injury	Work Related?	Auto Related	Acct Type
		- State -	
Injury Information	Referring Dr		
Did You Have Surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO	()	Date of Next Doctors Visit:	
Date of surgery			

Policy Information - Physical Therapy

PT - Name/Address of Insurance				
PT - Authorization #	From	To	# Visits	\$ Amount

Have you received any other therapy services this calendar year? YES NO

Have you received any home health therapy this calendar year? YES NO

If yes, when did you receive home health therapy? _____

Have you received any chiropractic treatment? YES NO

I acknowledge that my consent to receive treatment was voluntary and obtained prior to my initial evaluation that will be performed for the determination of the appropriateness of my plan of care/treatment program. I understand that I have the right to ask questions and receive adequate response to my questions at any time during the course of my care; including description of my condition/diagnosis, presenting signs and symptoms, pertinent evaluation findings, contraindications and precautions to treatment, expected benefits of treatment, and reasonable alternatives to treatment. I understand that I can terminate treatment at any time if I choose.

Patient Signature or Responsible Party Signature

Date