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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Information | | | | | | | | | | | |
|  | |  | |  | |  | |  | |  | |
| Patient Name: | | Enter Last Name | | Enter First Name | | M.I. | | Birthdate: | | yyyy-mm-dd | |
|  | | Last | | First | | M.I. | |  | |  | |
| Social Security #: | | Enter SSN | | Gender: | | Gender | | Marital Status: | | Select Status | |
| Street Address: | | Street Address | | | | | | | | | |
| City: | | Enter City Info | | State: | | State | | Zip Code: | | Enter Zip Code | |
| Occupation: | | Enter Occupation | | Employer’s Name: | | Enter Employer’s Name | | | | | |
| Home Phone: | Include Area Code | | Cell Phone: | | Include Area Code | | Work Phone: | | Include Area Code | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Subscriber | | | | | | | | | | | | |
| **Relationship to Patient:** | | | | Enter Relationship | |  | | |  | |  | |
| Patient Name: | | Enter Last Name | | Enter First Name | | M.I. | | | Birthdate: | | yyyy-mm-dd | |
|  | | Last | | First | | M.I. | | |  | |  | |
| Social Security #: | | Enter SSN | | Gender: | | Gender | | | Marital Status: | | Select Status | |
| Address: | | Street Address | | | | | | | | | | |
| City: | | Enter City Info | | State: | | State | | | Zip Code: | | Enter Zip Code | |
| Occupation: | | Enter Occupation | | Employer’s Name: | | Enter Employer’s Name | | | | | | |
| Emp. Address: | | Employer’s Address | | | | | | | | | | |
| Emp. City: | | Enter Emp. City | | Emp. State: | | State | | Emp. Zip Code: | | | Enter Zip Code | |
| Home Phone: | Include Area Code | | Cell Phone: | | Include Area Code | | Work Phone: | | | Include Area Code | |

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| --- | --- | --- | --- | --- | --- |
| Accident Information | | | | | |
|  |  |  | |  | |
| Accident/Injury Onset Date: | Format: yyyy-mm-dd | Surgery: | Yes or No | Date: | Format: yyyy-mm-dd |
| Accident Type: | Select Accident Type |  | |  | |
| Accident Details: | Enter Accident Details | | | | |

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| Insurance Information | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | |  | |  | | | | | | | |
| Primary Insurance Company: | | | | | Primary Insurance Co. | | | | | | | | Contact: | | Enter Contact Info | | | | | | | |
| Phone: | Include Area Code | | | | Policy/Claim #: | | | Policy/Claim # | | | | | | | | | | Group: | | | Group Info | |
| Insured’s Name: | | | Enter Insured’s Name | | | | | | | Authorization # / Precert #: | | | | | | | | | Enter Auth. / Precert # | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| Secondary Insurance Co. | | | | Enter Secondary Info | | | | | | | Contact: | | | Enter Contact Info | | | | | | | | |
| Phone: | | Include Area Code | | | | Policy Claim #: | | | Policy Claim # | | | | | | | Group: | | | | Enter Group Info | | |
| Insured’s Name: | | | Insured’s Name | | | | Social Security #: | | | | | Enter SSN | | | | | Birthdate: | | | | | Format: yyyy-mm-dd |

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| Referral Information | | | | | | | | | | | |
| Referring MD: | | Referring MD | | | Phone: | | Include Area Code | | NPI #: | NPI # Info | |
| Admit Date: | Format: yyyy-mm-dd | | | Rx Date: | | Format yyyy-mm-dd | | Therapist’s Name: | | | Enter Therapist’s Name |
| Body part/duration: | | | Enter body part/duration information | | | | | | | | |
| Have you received OT, chiropractic or physical therapy in the past year? | | | | | | | | Yes or No | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |

Patient Medical History

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | Enter your First & Last Name | | | | | | | | |
|  | | | | | | | | | |
| Referring Physician: | | Enter Referring Physician Info | | | | | | | |
|  | | | | | | | | | |
| Have you had surgery for this injury? | | | Y or N | Date of injury: | | yyyy-mm-dd | Date of surgery: | | yyyy-mm-dd |
|  | | | | | | | | | |
| Are you currently taking any prescription medication or non-prescription medication? | | | | | | | | Y or N | |
|  | | | | | | | | | |
| List ALL medications separated by commas: | | | | | List ALL medications separated by commas | | | | |
|  | | | | | | | | | |

Please select from the list below if you have had an evaluation for this injury by any of the following practitioners.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ☐ General Physician | ☐ Neurologist | ☐ Podiatrist |  |  |  |
| ☐ Orthopedist | ☐ Physical Therapist | ☐ Chiropractor |  |  |  |
| ☐ Emergency Room Physician | ☐ Occupational Therapist | ☐ Other: | Enter Other Info | | |

Please select if you have had any of the following special tests – check off all that apply:

|  |  |
| --- | --- |
| ☐ X-Ray | ☐ Bone Scan |
| ☐ MRI | ☐ EMG / NVC |
| ☐ CT Scan | ☐ Myelogram |

Please select to indicate current or past medical history – check off all that apply:

|  |  |  |
| --- | --- | --- |
| ☐ Arthritis/Swollen Joints | ☐ Gout | Orthopedic Conditions |
| ☐ Anemia | ☐ High Blood Pressure | ☐ Back: Injury/Surgery |
| ☐ Asthma/Bronchitis/Emphysema | ☐ Hernia | ☐ Neck: Injury/Surgery |
| ☐ Coronary Heart Disease | ☐ Infectious Disease | ☐ Shoulder: Injury/Surgery |
| ☐ Pacemaker/Defibrillator | ☐ Joint Replacement | ☐ Elbow/Wrist/Hand: Injury/Surgery |
| ☐ Diabetes | ☐ Pins/Metal Implants | ☐ Knee: Injury/Surgery |
| ☐ Emotional/Psychological Conditions | ☐ Osteoporosis | ☐ Foot/Ankle: Injury/Surgery |
| ☐ Epilepsy/Seizures | ☐ Pregnant |  |
|  | ☐ Stroke/TIA |  |
|  | ☐ Thyroid Condition |  |