|  |
| --- |
| 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 |

|  |
| --- |
| 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 |

|  |
| --- |
| 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 |

|  |
| --- |
| 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  |

|  |
| --- |
| 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 |   |