COMPREHENSIVE PHYSICAL THERAPY SOLUTIONS, P.L.L.C.

PATIENT NAME: _____ **DOB**:_____

ADDRESS: _____ **PHONE NUMBER**:_____

CITY, STATE, ZIP: _____ SSN:_____

EMAIL: _____

EMERGENCY/ ALTERNATE CONTACT (name): _____ PHONE: _____

HOW WOULD YOU LIKE APPOINTMENT REMINDERS? (circle one) PHONE E-MAIL TEXT

INSURANCE: _____ INSURANCE ID: _____CO-PAY: _____

POLICY HOLDER: _____ POLICY HOLDERS DOB: _____

POLICY HOLDER'S ADDRESS (street, city, state, zip): _____

STUDENT: (circle one) Y N

REFERRING MD: _____ DIAGNOSIS: _____

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR? (circle one) Y N

HOW MANY VISITS?_____ SAME DIAGNOSIS?:_____

SURGICAL HISTORY: _____

PAST MEDICAL HISTORY: (circle and list all applicable) Cancer/ HBP/ Diabetes/ Heart Problems/ Allergies

_____

MEDICATIONS (please include dosage): _____

_____

YOUR GOAL(S) FOR PHYSICAL THERAPY: _____

_____

INJURY/PAIN DUE TO: (circle one) FALL CAR ACCIDENT WORK INJURY ABUSE SURGERY SPORTS

WORKER'S COMPENSATION?: Y N NO FAULT? (AUTO ACCIDENT): Y N

HOW DID YOU HEAR ABOUT US?_____

PATIENT SIGNATURE:_____ DATE:_____

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WORKER'S COMPENSATION NO FAULT

WORKER'S COMPENSATION: Y N IF YES: DATE OF INJURY_____

ARE YOU CURRENTLY WORKING?: Y N OUT OF WORK DATE:_____

WORKER'S COMPENSATION CARRIER:_____

CARRIER'S ADDRESS:_____

WCB#:_____ CC#:_____

EMPLOYER:_____ EMPLOYER'S PHONE:_____

EMPLOYER'S ADDRESS:_____

NO FAULT: Y N IF YES: DATE OF ACCIDENT:_____

INSURANCE:_____ POLICY HOLDER:_____

NO FAULT/CAR ACCIDENT: Y N DATE OF ACCIDENT:_____

CLAIM NUMBER:_____ POLICY NUMBER:_____

INSURANCE COMPANY NAME:_____

INSURANCE COMPANY ADDRESS:_____

_____

INSURANCE COMPANY PHONE NUMBER:_____

ADJUSTER NAME:_____