REFERRING PHYSICIAN:_____

DATE OF INJURY/CONDITION:_____

Patient's Name_____ Home Phone #: _____

Address:_____ City:_____ State:_____ Zip Code: _____

Date of Birth: _____ Age: _____ Social Security #: _____-_____-_____

Email: _____

Patient's Employer: _____ Employers Phone #: _____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Spouse/Parent: _____ Social Security #: _____-_____-_____

Spouse/Parent Employer: _____ Employers Phone: _____

Who is responsible for account? _____ Phone #: _____

Mailing Address: _____

CURRENT MEDICATIONS

Per new insurance requirements, list must include all prescriptions, over-the-counter medications, herbals, and vitamin/mineral/dietary (nutritional) supplements and must contain the medications' name, dosage, frequency and route of administration.

Name of Medication	Dosage	Frequency	Route of Administration

I verify the above information is correct and will be used only by the Physical Therapist and his staff to ensure my health and safety. Patient's Initials _____