



PHYSICAL THERAPY INTAKE FORM

NAME: _____ DOB: _____
ADDRESS: _____
PHONE: _____ EMAIL ADDRESS: _____
SOCIAL SECURITY NUMBER: _____ PCP: _____
REFERRING PHYSICIAN: _____ DIAGNOSIS: _____
OCCUPATION: _____ EMPLOYER: _____
MARITAL STATUS: _____

EMPLOYER ADDRESS: _____
EMPLOYER PHONE: _____
ARE YOU EMPLOYED? FULL TIME ___ PART TIME ___ NOT EMPLOYED ___
SELF EMPLOYED ___ RETIRED ___

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____
ADDRESS: _____
PHONE: _____

PRIMARY INSURANCE COMPANY: _____
INSURANCE ADDRESS: _____
NAME OF SUBSCRIBER: _____ DOB: _____
NAME OF EMPLOYER INSURANCE IS THROUGH: _____
ID#/POLICY#: _____ GROUP#: _____

SECONDARY INSURANCE COMPANY
INSURANCE ADDRESS: _____
NAME OF SUBSCRIBER: _____ DOB: _____
NAME OF EMPLOYER INSURANCE IS THROUGH: _____
ID#/POLICY#: _____ GROUP#: _____

ACCIDENT INFORMATION
WAS THIS AN ACCIDENT? CAR ___ WORK ___ OTHER _____
DATE AND TIME OF ACCIDENT: _____
NAME OF INSURANCE COMPANY LIABLE FOR YOUR ACCIDENT: _____

WORKERS COMPENSATION:
NAME OF COMPANY WHERE ACCIDENT OCCURRED: _____
ADDRESS: _____
PHONE: _____

DATE YOU LAST SAW THE DR.: _____

DATES OF HOSPITALIZATION: _____