Moses Lake Sports Physical Therapy, PS

Date: _____

Patients Name:_____ SSN:_____ Birthdate:_____ Age:____

Address:_____ City/State/Zip:_____

Phone #: _____ Sex: M/F Marital Status: Married/Single/Divorced/Widow

Spouse:_____ Birthdate: _____ SSN: _____

Referring Dr.: _____ Primary Dr.: _____

Employer: _____ Phone #: _____

Emergency Contact: _____ Phone #:_____

Who's Responsible for this account: _____ Relationship: _____

Primary Insurance:_____ Secondary Insurance: _____

L&I Insurance: _____ Claim #:_____ DOI: _____

Auto Insurance: _____ Claim #: _____DOI: _____

Have you Attended Physical Therapy, Massage, Occupational, and/or Speech Therapy this year? Yes / No

If yes how many visits? _____

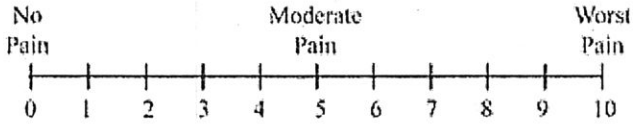
Have you received Physical Therapy for this injury? Yes / No

Is this condition getting progressively worse? Yes / No

When did your symptoms start? _____

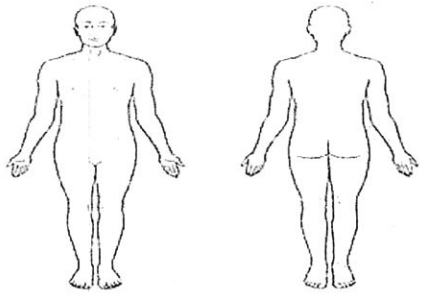
Please indicate your pain level:

At rest?_____ With activity?_____ Does your pain wake you up at night? Yes / No



What do you use for medication / pain relief?_____

Please indicate where your pain is located with an X:



Signature:_____ Date:_____