Shasta Physical Therapy

Patient Information:
Name:_____ Date:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:(___)_____Work Phone: (___)_____Cell Phone: (___)_____
Date of Birth:_____ SSN:_____ Gender:_____
Marital Status:_____ Email:_____

In Case of Emergency Contact:
Name:_____
Relationship:_____
Phone(___)_____

Employer:
Name:_____ Phone(___)_____
Address:_____
City:_____ State:_____ Zip:_____

Problem:_____
Date of Injury:_____ Date of Surgery:_____
Treating Physician:_____

Have you had any physical therapy or Chiropractic this Year? Yes / No # of visits:_____
Were you involved in a motor vehicle accident? Yes / No State:_____

Do you have any of the following:

Sensitivity to heat/ice:	Yes / No	Cardio pulmonary disease:	Yes / No
Diabetes:	Yes/ No	Metal Implants/Hardware:	Yes / No
Osteoporosis:	Yes / No	Previous Related Surgery:	Yes / No
Pacemaker:	Yes / No	Other:_____	

Primary Insurance:
Insurance Name and Plan:_____
ID#:_____ Group#:_____
Subscriber:_____ Relationship:_____ Date of Birth:_____

Secondary Insurance:
Insurance Name and Plan:_____
ID#:_____ Group#:_____
Subscriber:_____ Relationship:_____ Date of Birth:_____

I authorize payment directly to Shasta Physical Therapy the benefits payable for regular charges for this treatment. I understand that I am responsible for Charges not covered by my insurance.

I hereby authorize Shasta Physical Therapy to release or receive any medical records pertinent to medical history for the purpose of review, investigation or evaluation of an application or any purpose reasonable related to the above.

Signature_____ Date:_____