

LPT Patient Intake Form

Patient First Name _____ Middle Initial _____ Last Name _____

Home Phone (____) _____ Cell Phone (____) _____

~What is the best number for us to reach you to confirm your appointments? Home Cell Work

~ Do you wish to receive biweekly motivational and health tips via text? Yes No

Birth date ____/____/____ SSN _____ Male Female

Email address _____ ~Would you like to be added to our email list? Yes No

Street Address _____

City _____ State _____ Zip _____

Check appropriate box: Minor Single Married Divorced Widowed

Patient's Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

***** Has the patient received any type of physical/occupational therapy and/or home health services within the current calendar year? (for this injury or any other injury) YES / NO If yes, explain:** _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

Referring Physician _____ Primary Care Physician _____

Was this condition related to an accident or injury? Yes No

If yes, what type: Auto Injured at work Other: _____

Date of accident or injury _____ Accident Details _____

If this condition is related to an accident, please supply any third party payor information---- attorney, car insurance company name/phone/claim #, etc. Thank You.

Attorney/Adjuster Name _____ Claim #: _____

Phone # (____) _____

If patient is under the age of 18, please complete this section.

Parent's Name _____ Employer _____ Work phone _____

Parent's Date of Birth: _____ Parent's SSN: _____

If patient is a student, name of school/college _____ City _____ State _____

I hereby give my permission for authorized personnel of Lewy Physical Therapy to perform all necessary procedures and treatment as prescribed by my physician for the delivery of outpatient services.

Patient's Signature: _____

Date: _____

Parent/Guardian's Signature: _____