The Center For
BODIES IN BALANCE

Patient Information Form

Name: _____ **DOB:** _____ **Today's Date:** _____

Street Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:** _____

Primary Phone: _____ **(Home / Cell / Work)**

Secondary Phone: _____ (Home / Cell / Work)

Employer: _____ Job Title: _____

Emergency Contact: _____ **Phone:** _____

Relationship to Patient: _____

If patient is a minor, what is the name of Parent/Guardian?: _____

Relation to patient: _____ **Phone:** _____

Have you received Physical Therapy from another office during the last year? YES / NO
If Yes, how many visits have you used?: _____

Insurance Information: [Not needed if we take a copy of your card]

Primary Carrier: _____

Subscriber Name: _____ **Effective Date:** _____

Policy/Identification #: _____ **Group #:** _____

Secondary Carrier: _____

Subscriber Name: _____ **Effective Date:** _____

Policy/Identification #: _____ **Group #:** _____

Does your insurance(s) require a referral? YES / NO

If yes, do they need to come from your: PCP / Referring MD

Primary Care Physician

Name _____ **Address** _____

Name of Practice _____ _____

Phone # _____

Referring Physician (if applicable)

Name _____ **Address** _____

Name of Practice _____ _____

Phone # _____

Other Health Care Practitioners you are currently treating with:

Name _____ **Address** _____

Name of Practice _____ _____

Phone # _____

– OVER –

Goals for Physical Therapy: what would you like to accomplish in your work with our practice?

_____
_____
_____
_____
_____
_____

Pertinent Health History:

_____
_____
_____

Current Medical Problems – please include when your injury occurred:

_____
_____
_____

Please ✓ if you have had any of the following:

____ **Heart Attack**	____ **Stroke**	____ **Asthma**
____ **Heart Problems**	____ **Diabetes**	____ **COPD**
____ **High Blood Pressure**	____ **Head Injury**	____ **Depression**
____ **Low Blood Pressure**	____ **Neurological Disorder**	____ **Thyroid Concerns**

Please list current medications: _____
_____

Have you ever had surgery? **Yes / No**

If yes, please list:

Surgery	**Date**
_____	_____
_____	_____
_____	_____

Is there any chance you are currently pregnant? **Yes / No**

Please list any allergies you have: _____
_____

THE CENTER FOR BODIES IN BALANCE, LLC.

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