Endurance PHYSICAL THERAPY

Patient Demographics

Patient's Name:		Appointment Date:
Address:		
Home Phone:	Cell Phone:	Work Phone:
DOB:	SS#:	Email:
Gender: □ Female □ Male	Marital Status: □ Married □ Widowed □ Domestic Partner □ Single	
Employer:	Work Status: □ Full Time □ Part Time □ Not Working □ Retired □ Other	
Emergency Contact Name/Relationship:		Phone:

Insurance Information

Primary Insurance:	
Subscriber's Name:	Subscriber's DOB:
ID Number:	Group Number:
Secondary Insurance:	
Subscriber's Name:	Subscriber's DOB:
ID Number:	Group Number:

Motor Vehicle Accident/Worker's Compensation Insurance

Date of Accident:	□ Auto □ Work □ Other:	State in which accident occurred:
Insurance Company (Auto PIP or W/C):		Claim Number:
Address:	Claims Adjuster:	Phone Number:

Verification of Information

I verify that the above information is accurate (signature):

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Medical Questionnaire

Referring Physician:		PCP:
Pain Location:	How Long:	Intensity in past 24 hours (0-10): (0 = no pain, 10 = take me to the ER)
Date of Surgery (if applicable):		
Have you had treatment for this before: □ Y □ N	Where/How many visits:	

Current Medications (Prescription and OTC):
Allergies to Medication:

Describe your general health: □ Excellent □ Good □ Average □ Fair □ Poor
Do you exercise beyond daily activities: □ 5+ days/wk □ 3-4 days/wk □ 1-2 days/wk □ Occasionally □ Zero
List extra activities:
Do you smoke: □ Y □ N Packs/day: Do you drink: □ Y □ N Drinks/day:

Medical History: (I = individual F = family)			
□ I □ F Cancer Type:			
□ I □ F Diabetes Type:			
□ I □ F Arthritis	□ I □ F Rheumatoid	□ I □ F Osteoporosis	□ I □ F Broken Bones
□ I □ F Heart Disease	□ I □ F High BP	□ I □ F Vascular Problems	□ I □ F Blood Disorder
□ I □ F Stroke	□ I □ F Kidney Problems	□ I □ F Thyroid Problems	□ I □ F Lung Problems
□ I □ F Multiple Sclerosis	□ I □ F Head Injury	□ I □ F Epilepsy/Seizures	□ I □ F Parkinson's Disease
□ I □ F Stomach Problems	□ I □ F Depression	□ I □ F Infectious Diseases	(i.e. tuberculosis, hepatitis, etc.)
□ I □ F Other:			