ProActive
Physical Therapy and Sports Medicine

Patient Intake Survey

PATIENT INFORMATION:

_____ _____ Gender: M / F Age: _____
Last Name First Name

Birth Date: _____ SSN: _____ Status: Single / Married / Other

Cell Phone: _____ Home Phone: _____ OK to leave message? Y / N

Email: _____

_____ _____ _____ _____
Street Address City State Zip Code

Emergency Contact: _____ Relationship: _____ Phone: _____

Employment Status: Employed - Full Time / Part Time / Self-Employed / Unemployed / Disabled / Retired / Student / Homemaker

Employer: _____ Occupation: _____

Work Phone: _____ OK to leave message? Y / N

_____ _____ _____ _____
Street Address City State Zip Code

PHYSICIAN INFORMATION:

Referring Doctor Name: _____ Office Phone: _____

_____ _____ _____ _____
Street Address City State Zip Code

INJURY INFORMATION:

Date of Injury: _____ Body Part(s): _____

Impairment: _____

Injury Type: Work / Auto / Sports / Home / Other: _____ Lawyer Involved?: Yes / No

Attorney Name: _____ Phone: _____

_____ _____ _____ _____
Street Address City State Zip Code

Medications (please list all, whether injury-related or not): _____

Have you had other Physical/Occupational/Chiropractic Therapy for this injury? Yes / No If Yes, when & where: _____

_____

CONSENT TO TREAT

My signing below indicates that I acknowledge that the above information is correct to the best of my knowledge, and that I understand and give consent to a therapy evaluation and subsequent treatment provided and directly supervised by a licensed physical or occupational therapist and/or physical therapy assistant employed by ProActive Physical Therapy and Sports Medicine.

_____ _____ _____
Patient Signature Guardian Signature (if under 18) Date

(rev. 6/1/2013)