FOOTHILLS PHYSICAL THERAPY

PATIENT HISTORY

Date: _______________

Name: ____ DOB: ____________________

Address: ____ SS#: ____________________

City: _______________________________________ State: ____________ Zip: ______________

Home Phone: __________________________ Cell Phone: ________________________________

Work Phone: __________________________ Employer: __________________________________

Emergency Contact: ____________________ Contact Phone: ____________________________

Have you previously had physical therapy? Yes No

If yes: Where? ______________________________ When? _________________________

Was it for the same problem that you are currently seeking treatment? Yes No

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Primary Physician: ___________________________________ Phone: _______________________

Referring Physician: _________________________________ Phone: _______________________

How did you hear about us? ____

Health Insurance: ____

Address: ________________________ City: ___________________ State: _____ Zip: _______

ID#: __________________________________ Group #: ___________________________________

Health Insurance Subscriber: (circle one) Self Spouse Parent

If other than self: Name: ________________________________ DOB: __________________

Employer: ____

If this is an injury related to work or an auto accident – please fill in information below

Worker's Comp Carrier or Auto Insurance:

Date of Injury: ________________________ ID#: _______________________________________

Insurance: ____

Address: ________________________ City: ___________________ State: _____ Zip: _______

Contact: _______________________________ Phone #: ___________________________________