Abilities Abound Physical Therapy & Wellness Center

PATIENT INTAKE FORM

First Name: Last Name:	Date of Birth:
Mailing Address: City: State: Zip Code:	
Personal E-mail:	Work/Other E-mail:
Home Phone#: Work Phone#:	Cell/Other Phone#:

Preferred Methods of Contact (for self or authorized person):

☐E-mail ☐Home Phone ☐Work Phone ☐Cell/Other Phone

Primary Care or Referring Physician:	Phone#:
First, Last Name and Relationship of Emergency Contact:	Phone#:

Do you have a primary insurance policy? If yes, list name of primary and secondary insurance and policy number:

☐Yes ☐No Insurance Name: Policy#':

Secondary Name Insurance: Policy#:

This year, did you receive treatment from any of the following? If yes, list date or date range and number of visits:

Physical Therapist ☐Yes ☐No Date(s): _____ # of visits: _____
Occupational Therapist ☐Yes ☐No Date(s): _____ # of visits: _____
Speech Therapist ☐Yes ☐No Date(s): _____ # of visits: _____
Chiropractor ☐Yes ☐No Date(s): _____ # of visits: _____

Did you have or are you planning surgery? If yes, list date of surgery:

☐Yes ☐No

Did you sustain an injury at work? If yes, are you covered under an employer or union policy?

☐Yes ☐No ☐Yes ☐No

Are you currently employed?

☐Yes ☐No

Are your injuries automobile accident related? If yes, list date of automobile accident: Are you under litigation?

☐Yes ☐No

Have you made any changes to your choice of Medicare options in the last open enrollment period?

☐Yes ☐No

How did you hear about Abilities Abound Physical Therapy?

☐ Returning Patient
☐ Doctor
☐Insurance Company
☐ Walk-in /Close-by
☐ Friend or Family _____
☐ Internet (list search engine or website)
_____
☐ Employee_____

☐ AAPT Website
☐ Advertisement
☐Received an ☐ email or ☐ mailing
☐ Other
_____

Copy of cards? Y or N Appt date:_____ Appt Time:_____

Employee Initial _____ Date:_____