TeleTherapy Services Patient Intake Form

Full Name of Patient:_____

DOB(MM/DD/YYYY):_____ Gender: ___M ___F

Address:_____

Please check preferred method of contact: ___Call __Text __email_____Other

Phone numbers:_____(home)_____(work)_____(cell)

Email address:_____

Medicare Insurance (Subscriber ID)_____Policy Holder_____

Supplemental Insurance:_____

Your Primary Care Physician:_____Referring Physician_____

Have you had any Physical Therapy this year?___Yes ___No

What brings you to therapy today and what do you hope to achieve with therapy?

_____

_____

Significant Medical History(any surgeries, hospitalizations, recent imaging)

_____

List of Medications:_____

Emergency Contact:_____(Name)_____ _____(Relationship)

_____(contact number)

_____(initial) If you would like to receive a quarterly Teletherapy Services Newsletter.

_____ _____

Patient Signature Date