Patient Information

Name: _____ **Date**:_____

Phone: Cell _____ Home _____

Street: _____

City: _____ **State**: _____ **Zip**: _____

DOB: ___ / ___ / ____ **Age**: ____ **Email**:_____

Occupation: _____ **Work Phone**: _____

Emergency Contact: _____ **Phone**: _____

Relationship: _____

Primary/Referring Physician: _____ **Phone**: (if known)_____

Who May We Thank for Referring You to ERA? _____

Injury/Reason for needing PT: _____

_____

Date when symptoms began: _____ **Surgery Date**: ____ / ____ / _____

Have you received Physical Therapy for this, or another, condition this calendar year? Yes☐ / No☐

Home Environment: Do you live alone? **Y**☐**/ N**☐, If not, with whom?

Do you live in a Single or Multi-level Home? _____

Number of stairs: into home_____ to basement_____ to second level_____
Number of Railings: into home_____ to basement_____ to second level_____

Is this injury due to an auto accident or worker's compensation?Y☐/ N☐**Claim Filed?**Y☐ N☐

Name of auto/work comp adjuster/manager: _____

Claim # _____ **Phone**: _____ **Fax**:

_____

Primary Insurance Company: _____

ID# _____ **Group#** _____ **Phone#** _____

Name of Insured: _____ **DOB**: ____ / ____ / _____ **Relation**: _____

Secondary Insurance Company: _____

ID# _____ **Group#** _____ **Phone#** _____

Name of Insured: _____ **DOB**: ____ / ____ / _____ **Relation**: _____