Therapist:

Patient I.D. Verified _____
M.D. License Verified_____

**SCHAACK PHYSICAL THERAPY**

**PATIENT INFORMATION SHEET**

**DATE**_____

**NAME**_____ **SSN#**_____

**ADDRESS** _____

**CITY**_____ **STATE**_____ **ZIP**_____

**HOME PHONE**_____ **EMERGENCY CONTACT NAME**_____

**CELL PHONE**_____ **EMERGENCY CONTACT PHONE**_____

**EMAIL**_____ **HOW DID YOU HEAR ABOUT US?** _____

**DATE OF BIRTH**_____ **AGE**_____ **SEX: M F** **MARITAL STATUS: M S D W**

**IF MINOR, NAME OF PARENT/GUARDIAN**_____ **PHONE**_____

**EMPLOYER**_____ **JOB TITLE**_____

**BUSINESS ADDRESS**_____

**CITY**_____ **STATE**_____ **ZIP**_____

**WORK PHONE**_____ **EXT**_____ **SUPERVISOR**_____

**PRIMARY INSURANCE COMPANY**_____

**ADJUSTOR**_____ **CLAIM#**_____

**ADDRESS** _____ **PHONE**_____

**CITY**_____ **STATE**_____ **ZIP**_____

**WORK RELATED: Y N** **MOTOR VEHICLE ACCIDENT: Y N** **PERSONAL INJURY CLAIM: Y N**

**REFERRING PHYSICIAN:** _____ **DATE OF INJURY:** _____

**IF THIS IS A PERSONAL INJURY OR IF YOU WERE IN A MOTOR VEHICLE ACCIDENT, HAVE YOU RETAINED AN ATTORNEY? Y N**

**IF SO, PLEASE PROVIDE THE FOLLOWING INFORMATION:**

**ATTORNEY NAME:** _____ **PHONE:** _____