Patient Intake Questionnaire

Date: ____________________

Name: ____

Address: ____

City: ___________________________________ State: ________ Zip Code:____________________

Home Phone: _____________________________ Cell Phone: _______________________________

Date of Birth: ___________________________ SSN: _____________________________________

Email Address: ____

*By providing your e-mail address, you expressly consent to receive e-mails from us. We do not provide or sell your address 3rd party.

Marital Status: S M D W Sex: M F Former Patient: Yes No

How did you hear about us? ____

Patient Employer: ____

Occupation: ____________________________________ Full Time/Part Time: _______________________

Employer Address: _____________________________________ Phone: _____________________________

Emergency Contact Name: _______________________________Phone: _____________________________

Relationship to Patient: ____

Referring Physician: _____________________________________ Phone: _____________________________

Address: ____

If you are a Medicare patient, have you been involved in a home health episode? Yes No
(Nursing or Therapy Care in your home – Discharge Date: ____________)

Is this treatment due to injuries sustained in an accident (Auto, Work, or Wrongful Injury)? Yes No

If related to accident, what type of accident? ☐ Employment ☐ Motor Vehicle ☐ Personal Injury Claim (Wrongful Physical Injury)

Date and City/State of Accident: ____

Is this treatment covered by any other payer than your personal insurance? Yes No

If yes, who? ____

Are you represented by an attorney? Yes No

If yes, Attorney name: _________________________________ Attorney Phone: _______________________

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Auto/3rd Party Information

Were you or another party at fault? _______________ Date of Accident ___________________________

Name and address of other party____

Patient Auto Insurance Company _________________________ Claim # __________________________

Claims Mailing Address: ____

Insured's Name: ____

Other party Auto Insurance Company _______________________ Claim # ________________________

Claims Mailing Address: ____

Insured's Name: ____

Has the accident been reported? Yes No Is there a police report? Yes No

Workers Compensation

Employer's Name: _______________________________ Employer Ph: ___________________________

City/State where injury occurred? ____

Insurance Company: _________________________ Claim #: _________________________________

Adjuster Name: ___________________________ Phone #: __________________________________

Address: ________________________________ Fax #: ______________________________________

Case Manger Name: _______________________ Phone #: __________________________________

Address: _______________________________ __ Fax #: ____________________________________

Are you currently working full duty? Yes No

Private Insurance

Primary Insurance Company: ____

Name of Policy Holder? _____________________________ Date of Birth _____________________

Relationship to Patient ____

Policy Holder Employer: ____

ID # __________________________________ Group #: _______________________________

Secondary Insurance Company: ____

Name of Policy Holder? _____________________________ Date of Birth _____________________

Relationship to Patient ____

Policy Holder Employer: ____

ID # __________________________________ Group #: _______________________________

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