

INTAKE FORM

BODY IN BALANCE PHYSICAL THERAPY, PLLC

Patient Name: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Sex: M F Marital Status: M S D W D.O.B.: _____ Home Phone: (____) _____
Employer Name: _____ Address: _____ City: _____
State: _____ Zip: _____ Work Phone: (____) _____ Cell Phone: (____) _____
Email Address: _____

ACCIDENT / CONDITION INFORMATION

Was your injury due to an accident: Y / N Worker's Compensation Auto Other: _____
Date of Accident/Injury: _____ If Work. Comp., was patient out of work due to injury? Y / N
If yes, has patient returned to work / date returned? _____ Full or Restricted Duty? _____
Have you been treated by a Physical Therapist in the past? Y/N
If so, please indicate when _____ and for what condition _____

INSURANCE INFORMATION

Primary Insurance Co.: _____ Phone #: (____) _____
Member Name: _____ Relationship to Patient: _____
Member Address: _____ City: _____ State: _____ Zip: _____
Member D.O.B.: _____ Insured's I.D.#: _____ Group #: _____
Member's Employer: _____ Phone #: (____) _____
Secondary Insurance Co.: _____ Phone #: (____) _____
Member Name: _____ Relationship to Patient: _____
Member Address: _____ City: _____ State: _____ Zip: _____
Member D.O.B.: _____ Insured's I.D.#: _____ Group #: _____
Member's Employer: _____ Phone #: (____) _____

Emergency Contact

Name: _____ Phone #: (____) _____ - _____
Relationship to Patient: _____

How did you hear of Body In Balance Physical Therapy, PLLC?

Physician Referral (Name of Physician): _____
Other: **Please specify source** _____

I certify that the above information is accurate.

Patient/Guardian: _____ Date: _____

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