PATIENT INTAKE FORM

CARLSON PROCARE

Last Name:	**First Name:**	**Middle Initial:**	
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		
Email Address:			❑ **No Email**
Date of Birth: / /	**SSN:**	**Sex:** ❑ **Female** ❑ **Male** ❑ **Other**	
Preferred Appointment Reminder Method: (check one) ❑ **Text** ❑ **Cell Voicemail** ❑ **Home Voicemail** ❑ **Email** **Is it OK to leave a message?:** (check all that apply) ❑ **Text** ❑ **Cell Voicemail** ❑ **Home Voicemail** ❑ **Email**			
Employer:	**Status:** ❑ **FT** ❑ **PT** ❑ **None** ❑ **Retired** ❑ **Student**		
Work Phone:	**Occupation:**		
Emergency Contact:	**Phone:**	**Relationship:**	
Referring Physician:	**Phone:**	**Script?** ❑ **Yes** ❑ **No**	
Injury/Onset Date: / /	**Post -Surgical?:** ❑ **Yes** ❑ **No**	**Surgery Date:** / /	
Body Part/Diagnosis:			
Work Related: ❑ **Yes** ❑ **No**	**Accident Related:** ❑ **Yes** ❑ **No**	**Auto Related:** ❑ **Yes** ❑ **No**	
Adjuster: **Phone:**	**Attorney:** **Phone:**		
Accident Insurance:	**Claim #:**		
Have you had prior physical therapy this year? ☐ **Yes** ☐ **No**	**If yes, how many visits?**		
Are you receiving any home health services? ☐ **Yes** ☐ **No**	**If yes, Agency Name:**		
Primary Insurance Plan:			
Membership ID#:	**Group #:**		
Policy Holder Name:	**DOB:** / /	**Relationship to patient:**	
Address:	**City:**	**State:**	**Zip:**
Secondary Insurance Plan:			
Membership ID#:	**Group #:**		
Policy Holder Name:	**DOB:** / /	**Relationship to patient:**	
Address:	**City:**	**State:**	**Zip:**
Patient or Representative, please sign below if the above information is correct:			
Signature:		**Date:**	