Patient Information

CLIENT NAME
Last_____ First _____ Middle_____

Name you go by: _____

Parent / Guarantor Name
Last_____First_____Middle_____

Email Adress_____

Address_____

City_____ State_____ Zip_____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Cell Number: (_____) _____ - _____

Sex: (Circle One) Female Male Date of Birth: _____ / _____ / _____

Social Security Number: _____- _____ - _____ Marital Status:_____

Employer_____ Occupation: _____

Referring Physician:_____

Other Medical Specialist: _____

Emergency Contact

Name: _____ Phone#:_____

Relationship to Patient: _____

History of Injury / Illness / Disability

Explain reason for today's visit - Goals - please describe why you are bringing your child / yourself for therapy and what you would like to have happen.

_____

_____

Specialists (Name and specialty):_____

_____

_____

_____

Family Information:

Language(s) spoken in the home:_____

Names and ages of siblings:_____

List all medications you are allergic to: _____

List medications you are currently taking: _____

Pertinent Medical History:

___ Birth complications

Birth History: _____

Weeks gestation: _____

Delivery: ____ vaginal ___ forceps ___ c-section ___ vacuum extraction

Postpartum complications? ___ No ___Yes

NICU ___No ____Yes _____ Length of stay

Ventilator ___No ____Yes _____How long?

Biological child / birth order _____ Fertility Issues _____

Adopted___ Foster Child ___ (attach custody / DHR papers)

Pertinent Medical Issues / Procedures:

___ Chronic ear infections ___ Ear tubes

___ Childhood illnesses (measles, mumps, chicken pox)

___ Frequent strep throat ___ Tonsillectomy ___ Adenoidectomy

___ ER visits

___ Overnight hospitalizations

___ Surgeries

___ Previous orthopedic injuries

___ Genetic disorder

___ Seizures

___ Behavioral problems

___ Restrictive diet

___ Hearing problems

___ Vision problems

___ Other_____

Hand Dominance: Right Left Not sure

Equipment/orthotics:

_____

Other services received (Early Intervention, PT, OT, SP, BSC, TSS, etc.):

_____

Insurance Information

Insurance Company: _____

Policy or Contract Number: _____

Group Number: _____

Insurance Subscriber's Information

(Complete only if the patient is NOT the insurance subscriber)

NAME
Last_____ First _____ Middle_____

Relationship to patient: _____

Address_____

City_____ State_____ Zip_____

Insurance Subscriber's Sex: (Circle One) Female Male

Date of Birth: _____ / ____ / _____

Social Security Number: _____- _____ - _____

Employer_____ Occupation: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Mobile Number: (_____) _____ - _____

Has the patient had Physical Therapy at any other facility this year?

(Circle One) YES NO

If so, where? _____ How many visits? _____

How did you hear about Cradle to Rocker Physical Therapy?

_____

PATIENT/GUARDIAN SIGNATURE: _____

DATE_____