Patient Intake Form

ept Rehabilitation

Diagnosis:_____ Onset/Injury Date_____
Referring Doctor:_____

Patient's Name:_____ Home Phone:_____
Last First Middle

Mailing Address:_____ Message Phone:_____

City:_____ State_____ Zip_____ Sex: M_____ F_____

Social Security #_____ Birth Date:_____ Age:_____

Responsible Party Name/Address:_____

Emergency Contact Name/Phone #:_____

Current Employer Name/Phone #:_____

If this case is litigated, please give your attorney's name, address and phone #:
_____

Insurance Information:

Primary Insurance: Medicare Part B _____Yes _____No

Insurance Name:_____

Name of Insured:_____ DOB:_____

Secondary Insurance:

Insurance Name:_____

Name of
Insured:_____DOB:_____

Are you a student? __ Yes __ No Who is the holder of the policy? ____ Self ____Parent ___ Spouse____ Other

Have you had HOME HEALTH SERVICES IN THE LAST 60 DAYS? (Note: Patient cannot be seen by Home Health and Outpatient Physical Therapy at the same time.) _____Yes ____ No

Medical Information: Do you have any of the following conditions?:

Diabetes	___Yes ___No	Allergies to Ice	___Yes ___No
High Blood Pressure	___Yes ___No	Other Allergies	___Yes ___No
Heart Disease	___Yes ___No	Previous Surgery	___Yes ___No
Pacemaker	___Yes ___No	Hernia	___Yes ___No
Headaches	___Yes ___No	Seizures	___Yes ___No
Kidney Problems	___Yes ___No	IUD, Pregnant	___Yes ___No
Nervous Disorders	___Yes ___No	Metal Implants	___Yes ___No
Allergies to Heat	___Yes ___No	Others_____	

_____ _____
Patient Signature Date