Client Information Sheet (Please Print Clearly) Date: ___________________

Client Name:____

Date of Birth: ______________________________ SS#: _______________________________

Address: ____

City: ____ State: ________ Zip: ______________

Client's (or parent/guardian) Home Phone: ____

May we leave messages? □ Yes □ No

Client's (or parent/guardian) Cell Phone: ____

May we leave messages? □ Yes □ No

Would you like an appointment reminder by text? □ Yes □ No

Client's (or parent/guardian) E-mail: ____

Family/Emergency Contact Information (As appropriate):

Name_______________________________________ Phone: ____________________________

Relationship to you: ____

Financial/Employment/Insurance Information

Employment Status (□ Full-Time, □ Part-Time, □ Unemployed, □ Retired)

Employer's Name: __________________________________ Phone:______________________

Address: ____

Student: (□ Full-Time, □ Part-Time) Grade Level: _____________

Primary Insurance Coverage: (Get copy of card – front and back and attach to this form)

Insurance Company Name: ____

Secondary Insurance Coverage: (Get copy of card – front and back and attach to this form)

Insurance Company Name: ____

For Medicare Clients:

Have you received Physical Therapy earlier this year? □Yes □ No

If yes, how many visits (including Home Health) have you had? __________________________

Primary Care Doctor: ________________________________ **Phone**:____________________

~~~~~~

Office Use Only:

Referring physician: __________________________ **Phone:** _______________

Date of last visit: _____________________

Form Received: □**Yes** □ **No** **Date of Last Doctor Visit:**______________________
~~~~~~