PATIENT INFORMATION

Date: ______________ **Patient Name:** ____________________________________

Address: __________________ City: _____________ State: ____ Zip Code: _____

Home Phone: ____________________ Work Phone: ________________________

Cell Phone: ______________________ E-mail: ___________________________

Date of Birth_________________ Age: __________ Marital Status: ____________

Diagnosis: ____

Referral Source:
Name: ____________________________________ Phone: ____________________

Address: __________________ City: _____________ State: ______Zip Code:______

Emergency Contact:
Name: _________________________________ Relationship: _________________

Home Phone: ____________Work Phone: _____________Cell Phone: _____________

Primary Care Physician:
Name: ___________________________________ Phone: _______________________

Other Physicians:
Name: ___________________________________ Phone: ________________________
Name: ___________________________________ Phone: ________________________
Name: ___________________________________ Phone: ________________________

Other Health Practitioners:
Physical Therapist: ________________________ Phone: ________________________
Occupational Therapist: ____________________ Phone: ________________________
Speech-Language Pathologist: _______________ Phone: ________________________

Alternative Health Practitioners:
Name: ______________________________ Specialty: ___________________________
Phone: ______________________________
Name: ______________________________ Specialty: ___________________________
Phone: ______________________________

Please list all medications you take on a regular basis:
1. __________________________________ **4.** ___________________________________
2. __________________________________ **5.** ___________________________________
3. __________________________________ **6.** __________________________________

Please list any allergies and what type of reaction may occur:
1. __________________________________ **3.** ___________________________________
2. _________________________________ **4.**____________________________________