7932 W. Sand Lake Rd.
Suite 203
Orlando, FL 32819
(P) 407.355.9820
(F) 407.363.4571

Patient Information: **Initial Eval Date:** __________

First Name: ________________________________ MI: _____ Last Name: ____
Address: ____
Apt. _____________ City: ____________________________________ State: __________ Zip Code: _________________
Home Phone: _____________________ Work Phone: _______________________ Cell Phone: ______________________
Sex: M / F Marital Status: _____ Married ____Single _____ Widowed _____ Divorced
Date of Birth: _________________________ Age: ___________ SS#: ____
E-Mail: ____
Emergency Contact # ___________________________ Name/Relationship _______________________________
Have you had physical therapy in the past? ____Yes _____ No If yes, please answer the following:
When did you receive treatment?____
What diagnosis did you receive treatment for? ____

Doctor Information:

Referring Doctor (who wrote the Rx to come to therapy):____
Referring Doctor Address: ____
Referring Doctor Phone#: ____________________________________ Fax #: _______________________________
Primary Doctor:____ Phone #:_______________________________

Accident Information:

Is this work related? _____ Yes ____No Auto Accident? _____ Yes ____No Date of accident? ________________
Has the **NF/WC** Application been filed? _____ Yes _____ No Occupation: _________________________
Employer:____ Phone #: ____________________________________
What happened in the accident? ____
Is there an attorney? _____ Yes _____ No If yes, attorney name: _________________________________
Attorney address: ____ Phone # _________________________

NF/WC Insurance Carrier: ____

Address:____
Phone #: ____ Fax #: ____________________________________
Claim #: ____ Policy #: ______________________________________
Is there an adjuster or other agent? Y / N Name: ________________________ Phone #: _________________
Is this the patient's insurance? _____ Yes _____ No If no, who is the insured? Name:_______________________
Insured's relationship to the patient: ____ spouse ____ child ____ other Insured's D.O.B _________________
Does the patient have private insurance? _____ Yes ____No

Primary Insurance Co: _______________________________________ **Ins ID #**_________________________________

Is this the Patient's insurance: ____Yes ____No If no, the name of the insured ___________________________
Insured D.O.B: _________________________________ Relationship to the patient: ____spouse ____child ____other

Patient Signature: _____________________________________ **Date:** ________________________________