

# New Episode/Demographic Intake Form

(Please Print)

First name: \_\_\_\_\_ MI: \_\_\_\_\_ Last name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone/Ext: \_\_\_\_\_

Emergency Contact /Relationship/Phone: \_\_\_\_\_ / \_\_\_\_\_

## **Appointment Reminder Preference:**

☐ Home Phone/Voicemail

Cell Phone: ☐ Text ☐ Voice

☐ Email

☐ Please do not remind me of my appointments

## **Episode of Care:**

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Area of Treatment: \_\_\_\_\_ Date of Injury/Surgery: \_\_\_\_\_

Have you received Physical, Occupational, or Speech therapy within the past 12 months? ☐ YES ☐ NO

If yes, where and when? \_\_\_\_\_

## **Injury Related To:**

☐ Employment

☐ Employment Automobile Accident

☐ Personal Automobile Accident

☐ Third-Party Liability ☐ Not Applicable

(If check-marked, please fill out the back page)

## **Insurance Information:**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

**Patient's Relation to Insured:** ☐ Self ☐ \*Spouse ☐ \*Child

\*If not Self, please list insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: \_\_\_\_\_

Insured Address: \_\_\_\_\_

Print/Signature Name of Patient/Parent or Legal Guardian

Date

## **New Episode/Demographic Intake Form Continued**

**(Please Print)**

### **Work Comp (if related to work injury):**

State of Accident: (TX, NM, etc.): \_\_\_\_\_

State of Employment: (TX, NM, etc.): \_\_\_\_\_

Employer When Injured: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Workers Comp Insurance: \_\_\_\_\_

Workers Comp Insurance Address: \_\_\_\_\_

Case Manager/Adjuster Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Claim #: \_\_\_\_\_ Date of Loss/Injury: \_\_\_\_\_

If Unable to Work, List the Last Full Work Date: \_\_\_\_\_

Has a lawyer been retained? ☐ YES ☐ NO

### **Automobile Accident: (if related to an automobile accident)**

Did the Automobile accident happen while at work? ☐ YES ☐ NO

Is this your personal auto insurance? ☐ YES ☐ NO      Has a Lawyer been retained? ☐ YES ☐ NO

Auto Insurance Name: \_\_\_\_\_

Auto Insurance address: \_\_\_\_\_

Case Manager/Adjuster: \_\_\_\_\_

Case Manager/Adjuster Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Case Manager/Adjuster E-mail: \_\_\_\_\_

Claim #: \_\_\_\_\_ Date of Loss/Injury: \_\_\_\_\_

\_\_\_\_\_  
Print/Signature Name of Patient/Parent or Legal Guardian

\_\_\_\_\_  
Date