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: _____

Emergency Contact Name/Relationship: _____ Phone Number: _____

Employer: _____ Work Phone/Ext: _____

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

Get Better Faster…..Stay Better Longer!
Carlsbad Physical Therapy & Wellness Center, LLC

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