DOCKERY & ASSOCIATES
PHYSICAL THERAPY

DATE:________/________/______________

PATIENT NAME:____

DATE OF BIRTH:____________________AGE:________ SOCIAL SECURITY #:____________________

GENDER: MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED WIDOW DIVORCED SEPARATED

HEIGHT: ____________________ WEIGHT: ____________________

PHONE #:____________________ SECONDARY PHONE #:____________________

STREET ADDRESS:____

CITY:____________________ STATE:________________ ZIP CODE:____________

E-MAIL:____________________________ OCCUPATION:__________________

EMPLOYER:____________________ EMPLOYER PHONE:____________________

EMERGENCY CONTACT:________________________ RELATIONSHIP:__________________

EMERGENCY CONTACT NUMBER:____________________

INSURANCE COMPANY:____

SUBSCRIBER ID:________________________ GROUP:____________________

IF OTHER THAN THE PATIENT, PLEASE TELL US ABOUT THE POLICY HOLDER

POLICY HOLDER'S NAME:________________________ POLICY HOLDER'S DATE OF BIRTH:____________

POLICY HOLDER'S PHONE #:____________________RELATIONSHIP TO PATIENT:________________

POLICY HOLDER'S EMPLOYER:____________________EMPLOYER PHONE #:__________________

STREET ADDRESS OF POLICY HOLDER:____________________________________

CITY:____________________ STATE:________________ ZIP CODE:____________

REASON FOR VISIT:____

NEXT SCHEDULED APPOINTMENT WITH REFERRING PHYSICIAN:______/______/__________

HAVE YOU RECEIVED ANY PT, OT, SPEECH, OR CHIROPRACTIC SERVICES THIS YEAR? YES NO

ARE WE TREATING YOU FOR A CONDITION AS A RESULT OF AN ACCIDENT? YES NO DATE OF ACCIDENT/INJURY____/____/____

IF YES, WHAT KIND OF ACCIDENT? AUTO WORKER'S COMPENSATION OTHER

BRIEFLY DESCRIBE ACCIDENT:____

MEDICAL HISTORY INFORMATION:

DO YOU HAVE ANY ALLERGIES TO METAL, LATEX, MEDICATIONS, OR ADHESIVES? YES NO

IF YES, PLEASE DESCRIBE:____

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

HIGH BLOOD PRESSURE	OSTEOPEROSIS	ARTHRITIS	DIZZINESS
DIABETES	AUTOIMMUNE DISORDERS	FRACTURE	JOINT SWELLING
CANCER	HIV/HEP B/HEP C	METAL IMPLANTS	HEADACHES/MIGRAINES
SEIZURES	HEART TROUBLE	NUMBNESS/TINGLING	OTHER: _______________

DO YOU HAVE A PACEMAKER? YES NO

DO YOU HAVE A SPINAL STIMULATOR? YES NO

PAST SURGERIES:____

LIST OF CURRENT MEDICATIONS: ______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

ARE YOU CURRENTLY PREGNANT? YES NO

HOW DID YOU HEAR ABOUT US:

REFERRING PROVIDER	INTERNET
FRIEND	INSTAGRAM
FORMER PATIENT	FACEBOOK
HOSPITAL	OTHER:___________

IS THERE SOMEONE WE MAY THANK FOR REFERRING YOU TO US?: _______________________________________

Thank you for trusting us!

PATIENT'S SIGNATURE: **DATE:**

X____ ________/_______/____________