

## Client Information Form

As of: \_\_\_\_\_

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CLIENT:	DOB:	PHYSICIAN:
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### CLIENT INFORMATION:

Client's Street address	
City, State, Zip-Code	
Home telephone	(    )
Work telephone	(    )
Other number(s)	(    )
Social Security number	
Driver's license ID number/State	
Marital status (check box)	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other:
Name of spouse	
Employer	
Employer's Street address	
City, State, Zip-Code	

### BASIC MEDICAL INFORMATION:

Primary diagnoses	
Chief complaints	
Date of onset/procedure(s)	
Have you received therapy before?	
If yes, where and why?	

### EMERGENCY INFORMATION:

In case of an emergency please notify	
Relationship to patient	
Home telephone number	(    )
Work telephone number	(    )
Other number(s)	(    )

### REFERRING PHYSICIAN INFO:

Physician's name	
Specialty/type of practice	<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Orthopedic <input type="checkbox"/> Other:
Street address	
City, State, Zip Code	
Telephone number(s)	(    )
Approximate date of last exam/visit	

CLIENT:	DOB:	PHYSICIAN:
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**OTHER PHYSICIAN:**

Physician's name	
Specialty/type of practice	<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Orthopedic <input type="checkbox"/> Other:
Street address	
City, State, Zip Code	
Telephone number(s)	(     )
Approximate date of last exam/visit	

**PRIMARY INSURANCE INFO:**

Primary insurance		Number:
Policy holder's name		DOB:
Street address		
City, State, Zip-Code		
Telephone number	(     )	

**OTHER INSURANCE INFO:**

Other insurance		Number:
Policy holder's name		DOB:
Street address		
City, State, Zip-Code		
Telephone number	(     )	

**REFERRAL INFO:**

How did you hear about us?	<input type="checkbox"/> Doctor <input type="checkbox"/> Friend/Family <input type="checkbox"/> Phone Book <input type="checkbox"/> Other:
Person who referred you & date	
Company they work for	
Other Comments	

**OTHER INFORMATION/COMMENTS:**

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