

Intake Information Form/Contract
(Filled out by client/parent prior to therapy)

(Please bring insurance card to first appointment.)

Today's Date: _____
Patient name: _____
Patient DOB: _____ SS#: _____
Patient Phone#: _____ Email: _____
Parent/Guardian name (if client is a child): _____
Parent Phone #: _____ Email: _____
Address: _____
Insurance Plan & Member #: _____
Primary care physician: _____ Phone#: _____
Primary Diagnosis: _____
Date of Injury (if applicable): _____
Pertinent Previous Health Issues:

Pain Level (if applicable) on 1-10 scale: _____
Present Medications: _____
Patient (or parent) goals for therapy: _____

Contract:

*I agree to pay any co-pay at the end of each session attended. I also agree to give 24 hr. notice if I cannot attend a session, otherwise I will be required to pay in full. (Some exceptions, i.e. weather, may be considered) **If I fail to give 24 hr. notice for cancellations 3 times, services will be discontinued.***

By signing below, I am agreeing to honor this contract.

Signature: _____