WELCOME TO SIERRA NEVADA PHYSICAL THERAPY

You will be given a complete physical therapy examination on your first physical therapy visit. I will evaluate your musculoskeletal system and may review other records, such as your medical history and x-rays. The goal of this first session is to learn as much as I can about you and the difficulties you are having. This evaluation will enable me to plan the most effective and comprehensive treatment for you.

During your course of treatment, you will receive one on one care by a licensed physical therapist. The type of physical therapy you will receive will be based on your particular condition and your wellness goals. A treatment plan will be designed for you and will be presented on your first or second visit. Please feel free to comment and ask questions.

A health questionnaire is included on the following pages of this section. Please fill it out as completely as possible. This helps me to evaluate your condition and plan the best course of treatment for you. Answer each question and write freely on the discussion questions. Use the back of the page after you have printed the form if you need more room. On your first appointment bring your filled out questionnaire, any previous x-rays, and other information you think is helpful.

I look forward to meeting you,

Gregory J. Booth PT, OCS, CFMT

Owner and operator of Sierra Nevada Physical Therapy

Patient Information

Today's Date _____ **Email _____**

Patient Information

Name:_____ **Social Security #_____**

Date of Birth: _____

Address:_____
Street City State Zip
Mailing Address:
(if different from the one above)_____
Street City State Zip

Home Phone:_____ **Mobile Phone:_____**

Employer: _____ Occupation:_____

Employer Address: _____

Work Phone: _____ Ext: _____ Fax: _____

Marital Status: __ Single __ Married __ Divorced __Widow __ Minor

Spouse Information (if applicable)

Spouse's Name: _____ Date of Birth: _____

Employer: _____ Occupation:_____

Employer Address:_____

Work Phone: _____ Ext: _____ Fax: _____

Emergency Contact:

Name: _____ Relationship to patient: _____

Address:_____
Street City State Zip

Home Phone: _____ Mobile Phone: _____

Referral Source: (Whom could we thank for referring you to my clinic?)

Name: _____ Contact Phone: _____

Other Doctors / Providers responsible for your care

Primary Physician / Facility: _____

Office Phone: _____ Specialty: _____

Is this a work related injury? Yes No

Is your visit today related to an auto accident? Yes No

If you have answered yes to any of the two above questions, please describe on a separate sheet of paper.

Responsible Party

Signature: _____

Printed Name: _____

Relationship to the patient if patient did not sign: _____

Medical Insurance Information

Name of Primary Insured Person_____Relationship to Patient_____

Employer_____ Group#_____Insurance Co_____

Date of Birth_____Social Security#_____Employer ID#_____

Name of Secondary Insured Person_____Relationship to patient_____

Employer_____ Group#_____Insurance Co_____

Date of Birth_____Social Security#_____Employer ID#_____

By signing below you are validating that all the above information is correct to the best of your knowledge

_____	_____	_____
Print full Name	**Signature of Patient**	**Signature of Parent or Guardian if patient is a minor**