Peak PHYSICAL THERAPY & SPORTS MEDICINE CENTER

21195-B IH-35 North, Suite 201
Kyle, Texas 78640
512.268.0000 voice
512.268.0004 fax

Patient Information

Name: _____ Date: _____

Address: _____

_____

Home: _____ Work: _____ Cell: _____

◯ Male ◯ Female ◯ Married ◯ Child Date of Birth: _____ Age: _____

SSN# (Medicare, Tricare and Workers Comp only): _____

E-mail: _____

Emergency Contact: _____ Number: _____

Is this treatment due to a Motor Vehicle Accident or Work Injury? ◯ Yes ◯ No Date of Injury: _____

Policy Holder Information for Personal Insurance or Medicare

Name: _____ Relationship to Patient: _____

Address: _____

_____

Home: _____ Work: _____ Cell: _____

◯ Male ◯ Female Date of Birth: _____

SSN# (Medicare and Tricare only): _____

Employer: _____

Primary Insurance Carrier: _____

ID: _____ Group: _____ Phone Number: _____

Co-Pay: ☐ Co-Insurance: ☐ Deductible: ☐ Max PT PCY: ☐

Secondary Insurance Carrier: _____

ID: _____ Group: _____ Phone Number: _____

Workers' Comp Information / Personal Injury Protection

Employer: _____ Phone: _____

Adjustor: _____ Phone: _____

Claim Number: _____

Treatment Information

Referring Physician: _____ Phone: _____

Date of first doctor visit for this injury: _____ Date of Injury: _____

Have you had surgery for this injury? ◯ Yes ◯ No Date of Surgery: _____

Current Medications: _____

_____

How would describe your present health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any of the following medical or rehabilitative services for this injury?

☐ Physical Therapy	☐ Occupational Therapy	☐ Chiropractor
☐ Neurologist	☐ Orthopedist	☐ Emergency Room Care
☐ CT Scan	☐ MRI	☐ X-ray

If you checked one of the above boxes, how many visits? _____

What are the specific goals you would like to accomplish with physical therapy? _____

_____

_____

Do you have a follow-up scheduled with your doctor? ◯ Yes ◯ No Please provide date: _____

Patient Health Information

Have you ever had any of the following? Please check all which apply:

☐ Allergies	☐ Hearing Problems	☐ Vision Problems	
☐ Anemia	☐ Heart Disease / Angina	☐ Weakness	
☐ Arthritis	☐ Hernia	☐ Weight/Energy Loss	
☐ Asthma	☐ Heart Attack/Surgery		
☐ Blood Clot/Emboli	☐ High Blood Pressure	☐ Are you pregnant?	
☐ Bowel/Bladder Issues	☐ Infectious Disease	☐ Do you smoke?	
☐ Bronchitis	☐ Mental Disorders		
☐ Cancer	☐ Osteoporosis	Injury and/or Surgery:	
☐ Chemotherapy	☐ Pacemaker	☐ Neck	Date:
☐ Diabetes	☐ Pins/Metal Implants	☐ Shoulder	Date:
☐ Dizziness	☐ Severe Headaches	☐ Elbow	Date:
☐ Emphesema	☐ Shortness of Breath / Chest Pain	☐ Back	Date:
☐ Emotional Disorders	☐ Sleeping Problems	☐ Knee	Date:
☐ Epilepsy	☐ Stroke/TIA	☐ Leg	Date:
☐ Fainting	☐ Swollen Joints	☐ Ankle	Date:
☐ Head Injuries	☐ Varicose Veins		

DIAGRAM TO BE FILLED OUT IN OFFICE AT FIRST VISIT

Please mark the location(s) of your current symptoms on this diagram. If symptoms, which pertain to your current injury, are in more than one area, please be sure to include all areas on the diagram.

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