NORTHERN ARIZONA
PHYSICAL THERAPY ASSOCIATES

DATE OF EVALUATION: ______________________

Patient Intake

PATIENT INFORMATION

PATIENT'S FULL NAME (LAST, FIRST, MI)				
ADDRESS		CITY	STATE	ZIP CODE
DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER (XXX-XX-XXXX)	BIRTH SEX: (CIRCLE ONE)	MALE	FEMALE
CELL PHONE (XXX-XXX-XXXX)		EMAIL (XXXXXXX@XXXXX.COM)		
HOW DID YOU HEAR ABOUT US	WANT TO JOIN OUR ONLINE PORTAL YES OR NO	DOWNLOAD THE ONPATIENT APP IN THE APP STORE ON YOUR PHONE TO SCHEDULE APPOINTMENTS		

EMERGENCY CONTACT

EMERGENCY CONTACT NAME	RELATION	PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE	PROVIDE YOUR INSURANCE CARDS TO THE FRONT DESK TO VERIFY INSURANCE
WERE YOU INJURED IN A MOTOR VEHICLE OR WORKER COMPENSATION? YES OR NO	IF YES, WHAT WAS THE DATE OF ACCIDENT:	PREVIOUS THERAPY THIS YEAR OR CURRENTLY HOME HEALTH PATIENT? YES OR NO

CLINICAL INFORMATION

Date of injury: ______________________

Injury or diagnosis: ______________________

Pain at worst (0-10): ______________________

Pain right now (0-10): ______________________

Have you been treated for this in the past? ______________________

List any previous surgeries: ______________________

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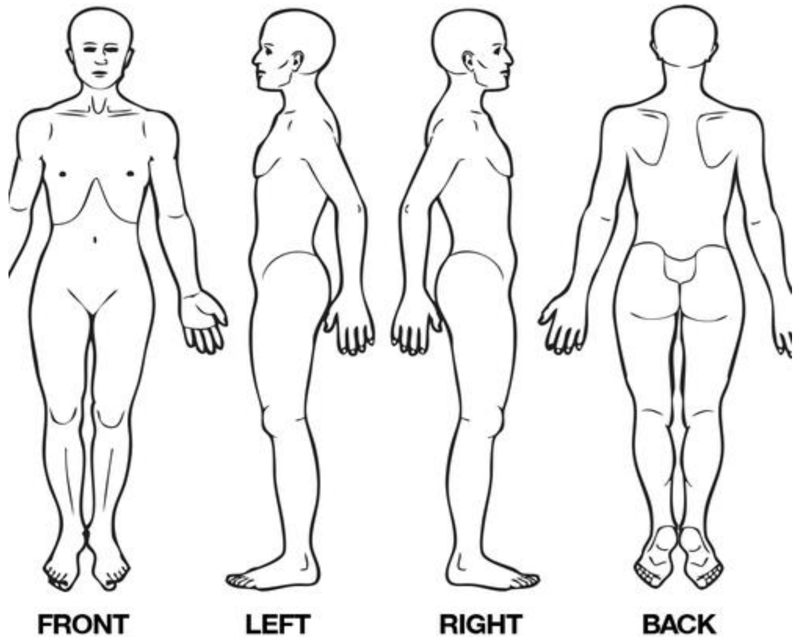

please indicate the location of your pain on the chart above

______________________________ Patient or Responsible Party Signature

______________________ Date

I acknowledge that all the information that I have supplied on these forms is true, accurate, current, and complete.