Date: ______________ Referring Physician: __________________________

Primary Care Physician: _______________________

Patient's Name: ____ Date of Birth: __________________________

Address: _______________________________________ City: ____________________ State: ______ Zip: _______

Social Security Number: ______________________________ Male ☐ Female ☐

Marital Status (Check One): Married ☐ Single ☐ Divorced ☐ Widowed ☐

Home Phone: (_____) ______________ Work Phone: (_____) _______________ Cell: (_____) __________________

Employer: ____________________________________ Occupation: ______________________________________

Address: __________________________________ City: ____________________ State: ______ Zip: ____________

Are you currently working? Yes ☐ No ☐ If not, why? ____

Have you ever been seen by Omni Rehab or Sequatchie Valley Physical Therapy? Yes ☐ No ☐
If yes, when? ___________________________ For what reason? ____
Are you currently receiving Home Health Physical Therapy? Yes ☐ No ☐

INFORMATION ABOUT THE INJURY OR WHAT YOU WILL BE TREATED FOR:

Date of onset/ injury: __________ If injured, was this due to an accident? Yes ☐ No ☐
If yes, check all that apply:
Work-Related ☐ Auto Accident ☐ Other Accident ☐ Litigation ☐
If work-related, has a workman's compensation claim been filed? Yes ☐ No ☐
If litigation case, Attorney: ____

MEDICAL HISTORY

Please list any serious illness, injury or surgery in the past five years:

____

IF THE INSURANCE IS IN ANOTHER PERSON'S NAME, PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE INSURED:

PRIMARY INSURANCE: ____
Insured's Name: ____ Date of Birth: ___________________

Social Security Number / ID#: _____________________ Relationship to Patient: _____________________

Employer: ____

SECONDARY INSURANCE: ____

Insured's Name: ____ Date of Birth: ___________________

Social Security Number / ID#: _____________________ Relationship to Patient: _____________________

Employer: ____