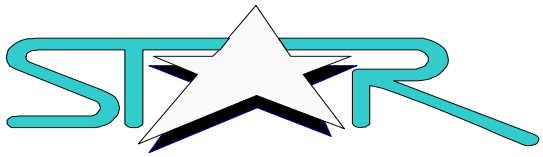

SPORTS THERAPY AND REHABILITATION, INC.

NAME: _____ DATE: _____

HOME ADDRESS: EMPLOYER NAME & ADDRESS:

_____ _____

_____ _____

CITY STATE ZIP CODE CITY STATE ZIP CODE

HOME ( ) _____ , CELL ( ) _____ , WORK ( ) _____ , EMAIL _____

SOCIAL SECURITY NO: _____ BIRTHDATE: _____

OCCUPATION: _____ HEIGHT: _____ WEIGHT: _____

CONTACT IN CASE OF EMERGENCY:

_____

NAME RELATIONSHIP PHONE NO

REFERRING PHYSICIAN AND ADDRESS: PRIMARY CARE PHYSICIAN AND ADDRESS:

_____ _____

HOW DID YOU LEARN ABOUT STAR CLINIC? PLEASE CHECK:

☐ PHYSICIAN REFERRAL ☐ INSURANCE PLAN ☐ FRIEND _____
☐ WEBSITE ☐ YELP ☐ FACEBOOK ☐ FREE CONSULT CARD ☐ OTHER _____

DIAGNOSIS: _____

DATE LAST SEEN BY PHYSICIAN: _____ SURGERY DATE: _____

DATE OF ONSET: _____ DATE OF INJURY/ACCIDENT: _____

IS THIS RELATED TO AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO
IS THIS RELATED TO A WORK INJURY? ☐ YES ☐ NO

Physical therapy involves physical touch for evaluating and treating injuries. I give permission to my therapist to use appropriate techniques to address my problem. I have the responsibility to tell my physical therapist if I am uncomfortable with a technique or if it reproduces pain or symptoms.

Signature of Patient: _____ Date: _____