



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
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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: _____