Currents
Physical Therapy + Wellness

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Patient Intake Form

Patient Information:

Last Name: _____

First Name: _____ Sex: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____

Zip Code: _____

Mobile: _____

Work Number: _____

Home Number: _____

Email: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Employer: _____

Occupation: _____

Physician: _____

Allergies or Medical Precautions: _____

Pacemaker? (please circle) YES or NO

Have you had COVID-19? Yes No

If Yes, please list date: _____

Have you been vaccinated for COVID-19? Yes No

Do Not Resuscitate: (please circle) YES NO

Emergency Contact: _____

Phone Number: _____

How do you prefer to be contacted regarding REMINDER NOTIFICATIONS? (please circle) TEXT CALL NONE

How did you hear about us?

KRML

Social Media

Website

Word of Mouth -- Referred by: _____