



**Adams & Giddings  
Physical Therapy, PC**

**Sport & Spine Specialists**

**PATIENT SUMMARY**

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Billing Address (If different from mailing address): \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

**MEDICAL INFORMATION**

Referring Physician: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ How long have you had this problem? \_\_\_\_\_

Have you had surgery for this problem? Yes \_\_\_\_\_ If so, date \_\_\_\_\_ No \_\_\_\_\_

Have you received any physical therapy or chiropractic for this problem before? \_\_\_\_\_

How much pain do you have with this condition? Rate on a scale of 0-10 (0 = none / 10 = severe): \_\_\_\_\_  
Intermittent /constant

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**AUTO/WORK COMP/PERSONAL INJURY CLAIMS ONLY**

Auto Claim: \_\_\_\_\_ Workers Comp Claim: \_\_\_\_\_ Personal Injury Claim: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Claim #: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone/Fax #: \_\_\_\_\_

**I certify that the above information provided by me is true and correct to the best of my knowledge. I hereby consent to treatment and procedures while a patient at Adams & Giddings Physical Therapy.**

Print Name

Signature

Date