KATHY BRAUN, PT, ATC
PHYSICAL THERAPIST

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:** _____