CORE PERFORMANCE
PHYSICAL THERAPY

**Name:** **Date:**

**Address:**

**City:** **State:** **Zip Code:**

**Date of Birth:** **Sex:** **Status:** **Single/Married/Widowed**

**Driver's License:** **Occupation:**

**Social Security:**

**Home Phone:** **Mobile Phone:** **Work Phone:**

**Email:**

**Would you like to receive email, text or phone reminders?**

**Emergency Contact Name:**

**Emergency Contact Phone Number:** **Relationship:**

**Referring Doctor:**

**Surgical History (with dates):**

**Do you have your Imaging Reports in hand?**

**List of Current Medication (for Medicare patients please page 6):**

**Previous Medical Condition:**

**Pacemaker?**

**Have you had any physical therapy this current year? Y N Are you currently receiving Home Health Care? Y N**

**Whom may we thank for referring you to our clinic?**

**We look forward to helping you recover!**