CORE PERFORMANCE
PHYSICAL THERAPY

Name: **Today's Date:**

Address:

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

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

Driver's License: **Occupation:**

Social Security:

Home Phone: **Mobile Phone:**

Email:

Do you prefer to receive email, text or phone reminders?

Emergency Contact Phone Number: **Relationship:**

Do you authorize Core Performance to disclose medical information to the above email address and emergency contact? Y N

Referring Doctor:

Surgical History (*please specify dates*):

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

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

Previous Medical Conditions:

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?

a) Doctor's office b) Family or friend c) Yelp d) Google search c) Other:

We look forward to helping you recover!