Royal Crown Healthcare Provider Inc.
COMPETENT & COMPASSIONATE HEALING

1300 W. Walnut Hill Lane, Suite 240
Irving, TX 75038
Phone: 972-756-9500
Fax: 972-756-9501
www.a1physicaltherapyclinic.com

A1 Physical Therapy Clinic of Irving at Las Colinas

PATIENT INTAKE FORM

PERSONAL INFORMATION

Name:_____/_____/_____
(Last Name) (First Name) (Middle Initial)

Age: _____ Date of Birth: _____ S.S.N. _____

Address:_____/_____/_____/_____
(Street#/PO Box) (City) (State) (Zip)

Telephone: (____)_____(____)_____(____)_____
(Home) (Work) (Cell Phone or Other)

E-mail address: _____

Gender: Female _____ Male _____

Are you (check one): Single _____ Married _____ Divorced _____ Widowed_____

Spouse/Significant Other's Name: _____

Your Occupation: _____(Circle) Full time/ Part time

Employer / School:_____

Address:_____/_____/_____/_____
(Street#/PO Box) (City) (State) (Zip)

Emergency Contact:_____ _____
(Name) (Relationship)

Emergency Contact Telephone Numbers:
(____)_____(____)_____(____)_____
(Home) (Work) (Cell Phone or Other)

What is the best way to communicate with you between office visits?
(E-mail, Home, Work, Cell Phone). Is there any place you do NOT want us to leave a message? _____

INSURANCE INFORMATION
– Please provide copy of front and back of Insurance card.

Insurance Co: _____ Insured's SSN: _____

Insured Full Legal Name: _____ Date of Birth: ___/___/___

Insured's Address:_____/_____/_____/_____
(Street#/PO Box) (City) (State) (Zip)

Insured's Employer: _____

Employer's Address: _____/_____/_____/_____
(Street#/PO Box) (City) (State) (Zip)

Do you have any secondary or additional Insurance plans? □ Yes □ No

Policy information:_____

REASONS FOR VISIT

What are the concerns for which you are seeking care? (Primary concern first)

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

Who is your primary care physician?

_____
(Name, Phone Number & Address if known)

For what concern did you last receive health or medical care?

_____

MEDICAL HISTORY

What are your current medical or surgical diagnosis?

_____

What are your past medical or surgical diagnosis/conditions? _____

_____

Have you sought physical therapy services before? If so, for what condition and when?

_____

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? _____

_____

_____

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient/Responsible Person: _____
Date:_____