New Episode/Case Form (PLEASE PRINT)

Patient information:

First name: ________________ MI: __ Last Name: ________________
DOB: _________________________

Medical Information for this episode of care:

Referring physician: ____________________

Primary Care physician: _________________

What part of your body will we be treating?
____

When did your symptoms start, or date of your injury?
____

If you've had surgery for this, what was the date of your most recent surgery?
____

Have you received any physical, occupational, or speech therapy in the past 12 months? This includes at a hospital, rehab center, nursing home, and/or in your home. ☐ Yes ☐ No

If yes where and when? ________________

Injury Related To: ☐ Employment ☐ Employment Automobile Accident
☐ Personal Automobile accident ☐ 3rd Party Liability ☐ Not Applicable
(If check-marked, please see back page)

Insurance information: (Please allow us to make copies of your insurance cards)
Primary Insurance: ______________________
Secondary Insurance: ___________________

Patient's relationship to insured: ☐ Self ☐ *Spouse ☐ *Child
*If not, "self" please list Insured's Name _________________________
DOB: _______
Insured's SS#: ______-_____-_____ Phone: ____________________
Insured's Address: ____

____ _____________
Signature of Patient/Parent or Legal Guardian Date

Workers Compensation (If work related injury please list info below)

New Episode/Case Form (PLEASE PRINT)

State where accident occurred: (TX, NM, etc.) ___________________________

State of employment: (TX, NM, etc.) _________________________________

Employer when injured:____

Employer Address: ____

Supervisor Name: __________________________ Phone #: ________________

Workers Comp Insurance: ____

Workers Comp Insurance address: ____________________________________

Case Manager/Adjuster Name: _______________________________________
Phone #: ________________ E-mail:____________________________________

Claim #: ______________ Date of Loss/Injury: ____________________________
If unable to work, list last full work date: _____________

Has a lawyer been retained: ☐ Yes ☐ No

Automobile Accident (If related to an automobile accident please list info below)

Did the Automobile accident happen while at work: ☐ Yes ☐ No

Is this your personal auto insurance? ☐ Yes ☐ No

Auto Insurance Name: ____

Auto Insurance address: ____

Case Manager/Adjuster: ____

Case Manager/Adjuster Phone #: _________________ Fax #: _______________

Case Manager/Adjuster E-mail: ____

Claim #: _______________________________ Date of Loss/Injury: ____________

Has a Lawyer been retained: ☐ Yes ☐ No

____ _______________
Signature of Patient/Parent or Legal Guardian Date