Propel Physical Therapy

Office Use Only
Evaluation Date: _____
Therapist: _____
Account #: _____

Patient Information

Name:_____ **Date:**_____

Address:_____
Street City State Zip

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

Sex: M / F **Date of Birth:**_____ **SSN:**_____

Emergency Contact/Relationship:_____ **Phone:**_____

Employer:_____ **Occupation:**_____

Are you receiving Home Health Care currently or in the last 60 days?
If yes, what agency?_____ Phone Number:_____

Insurance Information *Private Insurance patients will need to provide their primary/secondary insurance card(s)*

Primary Insurance Information
Insurance Company:_____ **Insured's Name:**_____

Policy Number:_____ **Insured's Date of Birth:**_____

Group Number:_____ **Insurance Phone Number:**_____

Secondary Insurance Information
Insurance Company:_____ **Insured's Name:**_____

Policy Number:_____ **Insured's Date of Birth:**_____

Group Number:_____ **Insurance Phone Number:**_____

Workman's Comp and MVA
Insurance Carrier Name:_____ **Claim Number:**_____

Adjustor Name/Phone Number:_____ **Date of Injury:**_____

Attorney Name/Phone Number: (If case is in litigation):_____

Do you have a pacemaker? Yes___ No___
Have you been diagnosed with Atrial Fibrillation (A-fib)? Yes___ No___
Do you take heart medication? Yes___ No___ If yes, what type?_____
Have you had a recent weight loss or gain? Yes___ No___
Do you have a history of cancer? Yes___ No___ If yes, what type_____
Are you currently pregnant? Yes___ No___ If yes, how many months? _____

Name:_____ **Date:**_____