Oregon Physical Therapy at Timberhill

Patient Intake Form

Date: ________________________

Name: _______________________________ Address: ____

City: _____________________________State: ____________________Zip Code: _____________________

Home Phone: (____)____________________________Cell Phone: (____)____________________________

Would you like a text message reminder? ☐ Yes ☐ No Cell Phone Carrier: _________________________

Email: ____

DOB: _____/_____/___________ Gender: ☐ Male ☐ Female Marital Status: S / M / D / W

Occupation: _______________________________Employer: ______________________________________

Work Phone: (____)________________ Emergency Contact: _______________________________________

Relation to emergency contact:________________________ Phone #: (____)_________________________

Primary Care Physician: __________________________Referring Physician: __________________________

Is this a ☐ Motor vehicle accident ☐ Workers Comp? If so, what was the date of injury? ___/___/_____

How did you hear about our clinic?

☐ My doctor's office ☐ I am a former patient ☐ Family/ Friend/ Colleague recommended ☐ My insurance company said you were in my network ☐ I did a search on the internet ☐ My trainer

☐ Other: ___________________

Please tell us who we can thank for sending you our way:

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*****PLEASE PRESENT YOUR INSURANCE CARD(S) AND PHOTO ID AT THE FRONT DESK*****

PATIENTS SIGNATURE: ____ DATE: ________________________