Back to Health
PHYSICAL THERAPY

PATIENT INFORMATION

Name _____
FIRST MIDDLE LAST

Address _____ Apt # _____

City _____ State _____ Zip _____

Cell Phone _____ Other Phone _____ circle: Home/Work

Date of Birth _____ Email _____

Is it okay to text and/or email: YES NO

Marital Status: Married Single Other Sex: M F

Emergency Contact Name _____ Phone _____

Primary Care Physician _____ Phone _____

Referral Source _____ Physician Therapist Friend Family Other

If you have had prior treatment for this problem, please describe briefly: _____

_____

Signature:_____ **Date**:_____

AUTHORIZATION FOR MINOR PATIENTS (Please complete if applicable)

I hereby request and authorize Back To Health PT, LLC physicians to perform evaluations and diagnostic tests, and render treatments to my MINOR SON/DAUGHTER. This authorization also extends to all other providers and office staff members. As of this date, I have the legal right to select and authorize health care services for the minor child named above. If my authority to select and authorize this care should be revoked or modified in any way, I will notify this office.

Name of Minor _____ Date of Birth _____

Name of Parent/Guardian (print) _____ Date _____

Signature of Parent/Guardian _____ Relationship to Patient _____

Witness _____