Workersâ€™ Compensation Physical Therapy Intake Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Email

Emergency Contact Name

Emergency Contact Phone

Employer & Insurance

Employer Name

Employer Phone Number

Insurance Company

Adjuster Name

Claim Number

Adjuster Phone

Injury Information

Date of Injury

Body Part(s) Injured

Describe how the injury occurred

Have you had prior physical therapy for this injury?

Physician Information

Referring Physician

Physician Phone

Additional Information

List current medications

Any allergies?

Other relevant medical history

Additional Comments