John A. Lewis Doctor of Physical Therapy

Patient Information:	**Date:**

Patient Name: Date of Birth:

Address: Male/ Female

City State: Zip:

Home # Cell #

Email: Social Security # :

Chief Complaint: How did it happen:

Referring Doctor:

Doctor address:

Doctor phone #: Fax #

Have you attended physical therapy this year? yes no

If yes, please explain:

Work Status

Employer: Work phone number:

Address:

City: State: Zip:

☐ Full Time ☐ Part Time ☐ Retired ☐ Student

☐ Unemployed ☐ Medical Leave ☐ Other

Workman's Compensation

Adjuster: Phone:

Claim number:

Auto/Attorney Lien

Adjuster/Attorney: Phone:

Claim #/Case #:

Med Pay (My auto insurance)