**Yorick Wijting, PT, DPT**
**Licensed Physical Therapist**

**9460 No Name Uno, Suite 250**
**Gilroy, CA 95020**
**(408) 707-0234**

# PATIENT INTAKE FORM

Date: ______________________ Past patient? ☐ Yes / ☐ No (if yes, only complete items that have changed)

Name (Last): __________________________________ (First) _____________________________ (M.I.) ______

Birth date: ____________________ Age: _________ Gender: ____________ SSN: _________________________

Email address: ____________________________________________ Drivers Lic #: ______________________

Home address: ____________________________________________________________________________

City: ____________________________________________ State: ________________ ZIP: ________________

Phone (home): _____________________ (work): ______________________ (mobile): ____________________

Preferred contact method: ☐ Home phone / ☐ Work phone / ☐ Mobile phone / ☐ Email

Emergency contact (name): ______________________________________ Phone: _______________________

Relationship to patient: ☐ Parent / ☐ Spouse / ☐ Sibling /☐ Other: ___________________________________

Referring physician: ____________________________ Primary care physician: _________________________

Occupation: _________________________________ Employment: ☐ Full time /☐ Part time / ☐ Not working

**INSURANCE**

Problem/injury requiring physical therapy: _______________________________________________________

Date of onset: ________________ Post-surgery?: ☐ Yes / ☐ No Surgery date: _________________________

Have you received therapy services for this problem before? : ☐ Yes / ☐ No When?: __________________

Have you been hospitalized for this problem/injury? : ☐ Yes / ☐ No When?: ____________________________

Primary insurance: ________________________________________________________________________

Policy holder name: ______________________________ Member ID: _______________ DOB: ___________

Relationship to patient: ☐ Self / ☐ Spouse / ☐ Child / ☐ Other: ____________________________________

Secondary insurance: ______________________________________________________________________

Policy holder name: ______________________________ Member ID: _______________ DOB: ___________

Relationship to patient: ☐ Self / ☐ Spouse / ☐ Child / ☐ Other:____________________________________

If Medicare, have you received Physical Therapy and/or Speech Therapy services this year? ☐ Yes / ☐ No

If yes, estimate combined amount billed for PT/SP services this year: ___________________________________

Patient/Personal Representative signature: _______________________________________________________