COASTAL HAND & OCCUPATIONAL THERAPY

Occupational Therapy with a hands on approach

Patient Name: ________________________ Age: _______ Date of Birth: ___________ Sex: ______

Address: ______________________________ City: ______________ State: ___________ Zip: ______

Home Phone: __________________________ Cell Phone: ______________ Work Phone: ___________

Driver Lic #: _____________________ Social Security #: ________________ Employer: ______________

If Minor,
Parent or Guardian's Name: ____________________ Parent Social Security #: ______________________

Primary Insurance: ____________________________ Phone: ____________________________________

Subscriber Name: _____________________________ Subscriber ID #: ___________ Group #: ________

Secondary Insurance: __________________________ Phone: ____________________________________

Subscriber Name: _____________________________ Subscriber ID #: ___________ Group #: ________

Occurred at: Work Auto Home Other Date of Injury or Symptoms: ____________

Briefly explain how injury occurred: ____

If work related,
Employer Insurance: ___________________________ Employer Phone: ____________________________

City: ____ State: _________ Zip: ____________

Adjuster Name: ______________________________ Phone: __________________ Claim #: _________

Referral Information:
Referring Physician Name: ______________________ Physician Phone Number: ____________________

Do you have a follow up appointment? Yes No Date of next appointment: _____________

Emergency Contact Name: ______________________ Relationship: ________________________________

Home Phone: __________________________ Cell Phone: ______________ Work Phone: ___________

Is there an Attorney involved in your case? Yes No
If yes,
Attorney Name: __________________ Phone: __________________ Fax: _________________________

Address: ______________________________ City: ______________ State: ________ Zip: ______

Patient: __________________ Date: _______ Parent (if minor): ________________ Date: _______
Signature Signature

Patient Confidential

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Occupational Therapy with a hands on approach

Patient Name: __________________________ Referring Doctor: ____________________________________

Have you had any Occupational or Physical Therapy for your present condition? Yes No

If yes, where? ____________________________ When (dates) ____

Female Patients: Are you pregnant? Yes No Possible (Maybe)

Please note if you now have, or have ever had, any of the following:

Condition			Condition		
Acquired Respiratory Distress Syndrome	Yes	No	Allergies	Yes	No
Angina	Yes	No	Angioplasty	Yes	No
Anxiety or Panic Disorder	Yes	No	Arrhythmia	Yes	No
Arthritis (rheumatoid/osteoarthritis)	Yes	No	Asthma	Yes	No
Atherosclerotic Disease	Yes	No	Back Pain	Yes	No
Cancer	Yes	No	Chronic Bronchitis	Yes	No
Chronic Obstructive Pulmonary Disease	Yes	No	Congestive Heart Failure	Yes	No
Coronary Artery Bypass	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Emphysema	Yes	No
Gastrointestinal Disease	Yes	No	Headaches	Yes	No
Heart Attack	Yes	No	Hearing Problems	Yes	No
Heart Disease	Yes	No	Hepatitis	Yes	No
Hernia	Yes	No	High Blood Pressure	Yes	No
HIV/AIDS	Yes	No	Incontinence	Yes	No
Kidney/Bladder Problems	Yes	No	Metal Implants	Yes	No
Nervous Disorders	Yes	No	Neurological Disease	Yes	No
Osteoporosis	Yes	No	Pacemaker	Yes	No
Peripheral Artery Disease	Yes	No	Pneumonia (recent)	Yes	No
Previous Accidents	Yes	No	Previous Surgery	Yes	No
Prosthesis/Implants	Yes	No	Seizures	Yes	No
Sensitivity to heat / ice	Yes	No	Sleep Dysfunction	Yes	No
Stents	Yes	No	Stroke or TIA	Yes	No
Surgery	Yes	No	Visual Problems	Yes	No
Other (note below)	Yes	No			

If yes to any of the above, please explain and give approximate dates (where appropriate):

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Please list any medications you are currently taking:

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____

Patient: ___________________ Date: _______ Parent (if minor): _________________ Date: _______

Signature Signature

Patient Confidential