Performance Lifestyles, Inc. **Date of referral _____**

Appt Date_____ Time_____

1. Patient Information

Name: Last_____ First_____ M.I.____
Gender M / F **Date of Birth_____**
Home Phone _____Work Phone_____
Cell Phone _____ Fax _____
Email _____
Street Address_____
City_____ State _____ Zip_____
Occupation_____
Employer_____ Address_____
Emergency Contact_____ Relationship_____
Day Phone_____ Evening Phone_____
Diagnosis_____ Date of Onset/Symptoms_____
Referring Physician_____NPI_____
Address_____Phone_____Fax_____
Primary Care Physician_____NPI_____
Address_____Phone_____Fax_____
Have you received physical therapy for any diagnosis this year? Yes / No
Please let us know how you heard of us _____

2. Insurance Information

*You do not need to complete this section if we have made a copy of your insurance card(s).

Subscriber_____
Primary Insurance_____ Subscriber D.O.B_____
Policy Number_____ Group Number_____
Address_____ City_____ State_____ Zip_____
Relationship to patient_____
Secondary Insurance_____ Subscriber_____
Policy Number_____ Group Number_____

3. Injury Information

*Complete this section only if your injury is work or auto related

Type of Injury: Auto / Workman's Compensation Date of Injury_____
Insurance Company_____ Claim Number_____
Street Address_____
City_____ State_____ Zip_____
Adjuster Name_____ Phone Number_____

Attorney _____ Phone _____