CORE Rehabilitation New Patient Intake Form

Patient Information:

First Name: _____ Last Name: _____ Gender: M / F

Date of Birth: _____ Age: _____ SSN: _____-_____-_____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Appointment Reminder Email: YES / NO

Email: _____ Injury: work or auto? _____

Employer's Name: _____ Occupation: _____

Source of Referral: Family/Friend Doctor Online Other: _____

Emergency Contact:

First Name: _____ Last Name: _____

Relationship: _____ Phone Number: _____

Medical History: (Please circle ALL that apply)

Asthma	Diabetes Type 2	High cholesterol	Seizures
Cancer	Heart attack	Osteoporosis	Stroke
Diabetes Type 1	High blood pressure	Rheumatoid Arthritis	Other: _____

Do you have a PACEMAKER? YES / NO

Please list all major or recent surgeries:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Please list all medications: (Or provide the receptionist with a list to copy)

_____ _____

_____ _____