Patient Information: New Patient Intake Form **CORE Rehabilitation**

Name: _____ Date of Birth: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Occupation: _____

Appointment Reminder Email: YES / NO Email: _____

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

Emergency Contact:

Name: _____

Relationship: _____ Phone Number: _____

Insurance Information:

Insurance Company Name: _____

If other than self, please complete the following on the policy holder:

Name: _____ Date of Birth: _____ Relationship to Patient: _____

Injury: Workers' Comp or Auto Accident Employer's Name: _____

Circle one if applicable.

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: _____

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

_____ _____

_____ _____