



Kevin Bird, M.S., P.T. | Bria Livingston, D.P.T. | Julianne Fisher, D.P.T, ATC | Jessica Lemus, D.P.T.

Patient Information

Name: _____ DOB: _____ Birth Gender: M / F

Please specify a preferred pronoun if desired: _____

Social Security #: _____ Employer: _____

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

Daytime #: _____ Alternate #: _____ Email: _____

Preferred Contact method: Phone / Email / Other : _____ Messages Ok? Y / N

Emergency Contact: _____ Relationship _____ # _____

Referring Physician: _____ Primary Care Physician: _____

Injury Information

Date of Injury: _____ Nature of Injury: (Work/ Auto/ Personal) _____

Have you seen another physical therapist related to this injury? Y / N

Have you consulted or retained an attorney in connection with this injury? Y / N

Attorney Name: _____ Case Number: _____

Address: _____ Phone # _____

Past Medical History

Latex Allergy: Y / N Pacemaker/other implanted device? Y / N Specify: _____

Surgeries: _____ Chronic Medical Conditions: _____

Allergies: _____ Activity limitations: _____

Medications (Or provide list): _____

I acknowledge, by signing below, that I have read and understand the policies regarding payment, privacy practices, consent to treat, authorization of assigned benefits, and cancellations/no shows of Bird Physical Therapy.

Patient/Guardian Signature: _____ Date: _____