



BIRD PHYSICAL THERAPY

Kevin Bird, M.S., P.T. | Jessica Lemus, D.P.T.

Patient Information

Name: _____ DOB: _____ Birth Gender: M / F
Please specify a preferred pronoun if desired: _____ Social Security # _____
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: _____
(Dr. Full Name) (Dr. Full Name)

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: _____