Suffolk Chiropractic
Rehabilitation &
Physical Therapy

T. 631.772.7000
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439 William Floyd Parkway, Shirley NY 11967
INFO@SCR-PT.COM

INTAKE SHEET

REFERED BY:______________________________

LAST NAME:______________________ FIRST NAME:________________ DOB__________ M_____F____

ADDRESS:__________________________________CITY:__________________STATE:________ZIP:______

PHONE# HOME__________________CELL#__________________ EMAIL:__________________________

INSURANCE TYPE: ___AUTO ___WORK ____PRIVATE DATE OF INJURY:____________________

NAME OF INS. COMPANY:______________________ INSURED________________ DOB__________

POLICY ID # ______________________________ CLAIM #________________________________

NATURE OF COMPLAINT / INJURY____

WORK RELATED INJURYS:

WCB#______________________ CARRIER CASE# / CLAIM# ___________________________

OCCUPATION:__________________ EMPLOYER PHONE_______________CONTACT PERSON:_______________

EMPLOYER:____

EMPLOYERS ADDRESS:________________________________CITY_____________STATE______ZIP_______

DID YOU REPORT INJURY___YES___NO TO WHOM?_______________________ DATE OF INJURY__________

AUTO ACCIDENTS:

DATE OF ACCIDENT____________________ ___ DRIVER ____PASSENGER ___PEDESTRIAN

WERE YOU ON THE JOB WORKING AT THE TIME OF ACCIDENT?____YES____NO

WERE YOU SEEN BY A DOCTOR?____YES_____NO WHO?____

DID YOU GO HOSPITAL ___YES___NO IF YES, WHERE?____

X-RAY TAKEN?___YES___NO IF YES, BY WHOM?____

NAME OF ATTORNEY:______________________________________ATTORNEY'S PHONE#_______________