KINETIC EDGE
PHYSICAL THERAPY

GENERAL INFORMATION

CLIENT'S LEGAL NAME _____ TODAY'S DATE _____/_____ /_____
CLIENT'S PREFERRED FIRST NAME _____
ADDRESS _____ DATE OF BIRTH _____/_____ /_____
CITY _____
STATE _____ ZIP _____ Male or Female
HOME PH# (_____) _____
CELL PH# (_____) _____
WORK PH# (_____) _____x_____ Single Married Divorced
EMAIL _____ Widowed Other
If client is a minor, PARENT OR GUARDIAN NAME(S):
_____
Who is your family physician? _____
Would you like us to send him/her an update? **Y N**

EMERGENCY CONTACT

NAME _____ RELATIONSHIP_____
ADDRESS _____
CITY _____ STATE_____ ZIP _____
HOME PH# (_____) _____ CELL PH# (_____) _____
WORK PH# (_____) _____x_____

HOW DID YOU FIND OUT ABOUT US? (Please check the box that applies)				
□ Print Ad	□ Website	□ Social Media	□ Google	□ Kinetic Edge Team Member:
□ Physician	□ Returning Client	□ Workshop	□ Radio	□ Other:
□ Walk In	□ High School Athlete	□ Employer	□ Friend/Family Member:	

AUTHORIZATIONS (Initial all lines that are appropriate.)

_____ I authorize Kinetic Edge Physical Therapy to provide me, or the client for whom I am legally responsible, medical treatment.
_____ I authorize Kinetic Edge Physical Therapy to contact me via phone, mail or email regarding issues related to my treatment.
_____ I understand that Kinetic Edge Physical Therapy adheres to the HIPAA policy and I understand that my personal information will be kept confidential. *
_____ I authorize Kinetic Edge Physical Therapy to send me appointment reminders. Select which method you would like reminders: _____ Text _____ E-mail
_____ I authorize Kinetic Edge Physical Therapy to send my client statement through a secure email link or e-statement to the email address above.
_____ I authorize Kinetic Edge Physical Therapy to disclose information regarding my injury, as well as my general fitness to play, to my coaches or teachers as needed for safe sport or class participation. *
_____ I authorize Kinetic Edge Physical Therapy to disclose information to the following individuals:
Name: _____ Relationship: _____ Ph #: _____
Name: _____ Relationship: _____ Ph #: _____
*Refusing to initial will not prevent you from receiving treatment.

_____ _____
Signature of Client or Authorized Person Date