Carolina Therapeutics, PLLC

Patient Information

Patient Name: _____ Date of Injury: _____

Mailing Address: _____ City, State, Zip: _____

Phone #: _____ DOB: _____ Social Security #: _____

Referred By: _____ Referring Provider Fax #: _____

Patient Intake Questionnaire

1. Were you injured in an auto accident? ☐ **Yes** ☐ **No**
2. Were you injured while working? ☐ **Yes** ☐ **No**
3. Are you represented by an attorney? ☐ **Yes** ☐ **No**

If you answered question No. 2 "Yes":

Law Firm Name: _____ Law Firm Telephone: _____

Firm Address: _____ City, State, Zip: _____

4. Do you have private health insurance? ☐ **Yes** ☐ **No**

If you answered question No. 4 "Yes":

Name: _____ Insurance ID #: _____ Insurance Group #: _____

5. Are you covered by Medicaid? ☐ **Yes** ☐ **No**
6. Are you covered by Medicare? ☐ **Yes** ☐ **No**
7. Are you covered by a Worker's Compensation Insurance Carrier? ☐ **Yes** ☐ **No**

If you answered question No. 7 "Yes":

Carrier Name: _____ Address: _____ Claim #: _____

Adjuster Name: _____ Phone #: _____ Fax #: _____

8. Have you received a therapy referral from a physician? ☐ **Yes** ☐ **No**

Present Complaints

Please Describe: _____

Did you go to the Hospital?
☐ **Yes** ☐ **No** (If yes, where?) _____

Have you had any x-rays performed?
☐ **Yes** ☐ **No** (If yes, state the findings:) _____