

## St. Louis Physical Therapy Patient Data Sheet

PATIENT NAME _____					
	LAST	FIRST	MI		
ADDRESS _____					
	STREET	CITY	STATE	ZIP	
PHONE: HOME (____) _____		WORK (____) _____		CELL (____) _____	
BIRTH DATE _____		SEX: M    F	MARITAL STATUS: M   S   D   W		
SS# _____					
E-MAIL ADDRESS _____			ACTIVELY EMPLOYED Y   N		
EMPLOYER _____			OCCUPATION _____		
EMPLOYER ADDRESS _____					
	STREET	CITY	STATE	ZIP	

How did you hear about us? _____				
My initial phone contact with STLPT was a positive experience.				
Strongly Agree _____	Agree _____	Disagree _____	Strongly Disagree _____	

EMERGENCY CONTACT NAME _____	PHONE # (____) _____
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<u>RESPONSIBLE PARTY INFORMATION</u>					
<b><i>*PLEASE FILL OUT COMPLETELY IF RESPONSIBLE PARTY IS NOT "SELF"*</i></b>					
RELATION TO PATIENT:    SELF    SPOUSE    PARENT    OTHER					
NAME _____					
	LAST	FIRST	MI		
ADDRESS _____					
	STREET	CITY	STATE	ZIP	
PHONE: HOME (____) _____		WORK (____) _____			
SS# _____		SEX    M    F	BIRTH DATE _____		
EMPLOYER _____			ACTIVELY EMPLOYED    Y    N		
EMPLOYER ADDRESS _____					
	STREET	CITY	STATE	ZIP	

DATA SHEET COMPLETED BY <b>X</b> _____	DATE _____
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REFERRING PHYSICIAN _____				
ADDRESS _____				
	STREET	CITY	STATE	ZIP
PHONE: (____) _____		FAX: (____) _____		