FREEDOM THERAPY, 2050 S. Clinton Ave, Rochester, New York 14618

Client Information Form

As of: _____

NAME (Last, First):	DOB:	PHYSICIAN:

CLIENT INFORMATION:

Client's Street address	
City, State, Zip-Code	
Home telephone	( )
Work telephone	( )
Other number(s)	( )
Social Security number	
Driver's license ID number/State	
Marital status (check box)	❑ Single ❑ Married ❑ Widowed ❑ Other:
Name of spouse	
Employer	
Employer's Street address	
City, State, Zip-Code	

BASIC MEDICAL INFORMATION:

Primary diagnoses	
Chief complaints	
Date of onset/procedure(s)	
Have you received therapy before?	
If yes, where and why?	

EMERGENCY INFORMATION:

In case of an emergency please notify	
Relationship to patient	
Home telephone number	( )
Work telephone number	( )
Other number(s)	( )

REFERRING PHYSICIAN INFO:

Physician's name	
Specialty/type of practice	❑ Primary Care Physician ❑ Orthopedic ❑ Other:
Street address	
City, State, Zip Code	
Telephone number(s)	( )
Approximate date of last exam/visit	

NAME (Last, First):	DOB:	PHYSICIAN:

OTHER PHYSICIAN:

Physician's name	
Specialty/type of practice	❑ Primary Care Physician ❑ Orthopedic ❑ Other:
Street address	
City, State, Zip Code	
Telephone number(s)	( )
Approximate date of last exam/visit	

PRIMARY INSURANCE INFO:

Primary insurance		Policy / ID #:
Policy holder's name		DOB:
Street address		
City, State, Zip-Code		
Telephone number	( )	

OTHER INSURANCE INFO:

Other insurance		Policy / ID #:
Policy holder's name		DOB:
Street address		
City, State, Zip-Code		
Telephone number	( )	

REFERRAL INFO:

How did you hear about us?	❑ Doctor ❑ Friend/Family ❑ Phone Book ❑ Other:
Person who referred you & date	
Company they work for	
Other Comments	

OTHER INFORMATION/COMMENTS (Please specify preferred location):