



Deer Park Physical Therapy
& Sports Conditioning

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509-991-2914

707 South Park St.
Deer Park, WA 99006

PATIENT INFORMATION:

Patient Name: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ SS# _____

Phone: (H) _____ (C) _____

INSURANCE INFORMATION:

Responsible Party: _____ Relation to Patient: self spouse child other

Address: _____ City/State/Zip: _____

Phone: (H) _____ (C) _____

Date of Birth: _____ SS# _____

Insurance Company: _____

Date of Injury: _____ Work Related: YES / NO Auto Accident: YES / NO

HEALTH INFORMATION:

Is this your first Massage? YES / NO

Reason for visit: _____

Please list major illnesses, surgeries or injuries during past 5 years: _____

Please list all medications taken regularly: _____

Are you currently under the care of a health care provider?

Name: _____ Phone: _____

Contract for care:

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for care:

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature: _____ Date: _____