Section I: Patient Information

Patient name: ____ Date of Birth: _____________
Address: _______________________________ City: ______________ State: _______ Zip: _________
Phone #: _______________________________ Email: _______________________________________
Occupation: ____________________________ Employer: _____________________________________
Emergency Contact:
Name: _________________________________ Relation: _________________ Phone: ____________

Section II: Privacy

I authorized Dr. Paul Reuteman DPT to release all medical information and records to my insurance company or physician.
Signature of Patient: ____ Date: ____________________
Can we leave appointment or medical information on your voicemail: Yes / No
Do you work with a personal trainer or a member of the fitness staff at RCW? Yes / No

Section III: Consent to Treat
I consent to physical therapy treatment by Dr. Paul Reuteman PT. I understand that I can request more information about my condition, prognosis, treatment plan or treatment procedures at any time.
Signature of Patient: ____ Date: ____________________

Use the diagram to indicate where your primary symptoms are: