



PERSONAL INFORMATION

First Name: _____ MI: _____ Last Name: _____
Address: _____ City _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Social Security #: _____ Birthdate: _____ Age: _____ Sex: M F
Occupation: _____ Employer's Name: _____
Work Address: _____ City _____ State: _____ Zip: _____
Marital Status: _____ Spouse's Name _____ # of Children: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
How were you referred to us? _____

INSURANCE INFORMATION

Primary Insurance Company: _____ I am the policy holder: (Circle one) Yes No
Secondary Insurance Company: _____ I am the policy holder: (Circle one) Yes No

If yes, skip the Policy Holder Information Section and provide a copy of the current insurance card to Triton Aquatic & Land Therapies. If no, please complete Policy Holder Information Section below and provide current insurance card to Triton Aquatic & Land Therapies.

POLICY HOLDER INFORMATION (If other than self)

Policy Holder Name: _____
Relationship to patient: (Circle One) Parent Spouse Self (If secondary insurance)
First Name: _____ MI: _____ Last Name: _____
DOB: ____/____/____ SSN: _____
Address: _____ City _____ State: _____ Zip: _____
Phone: Home: _____ Cell: _____ Work: _____
Employer's Name: _____ Phone #: _____ Contact: _____
Address: _____ City: _____ State: _____ Zip: _____

Please provide a copy of your drivers license and insurance card. Thank you.

Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____



NEW PATIENT HISTORY

Welcome to Triton Aquatic & Land Therapies. Please help us by completing this questionnaire.

Date: _____

First Name: _____ MI: _____ Last Name: _____

Who may we thank for referring you to us? _____ Phone #: _____

What brought you to us? *Please check all that apply.*

Ankle pain

Thoracic

Foot Pain

Fibromyalgia

Hip Pain

Hand/Wrist Pain

Injury - Upper Limb

Injury - Lower Limb

Knee - Chronic Pain

Joint Pain/ Tenderness

Shoulder Pain

Muscle Tenderness/ Stiffness

Spine

Lumbar

Cervical

General

Other: _____

Location of Pain: _____ Severity (0-10) Scale: _____

Is there anything else you'd like to share with us about your condition? _____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____