TRITON
AQUATIC & LAND THERAPIES

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: _____

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NEW PATIENT HISTORY

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

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
- ☐ Foot Pain
- ☐ Hip Pain
- ☐ Injury - Upper Limb
- ☐ Knee - Chronic Pain
- ☐ Shoulder Pain
- ☐ Spine
- ☐ Cervical
- ☐ Other: _____
- ☐ Thoracic
- ☐ Fibromyalgia
- ☐ Hand/Wrist Pain
- ☐ Injury - Lower Limb
- ☐ Join Pain/ Tenderness
- ☐ Muscle Tenderness/ Stiffness
- ☐ Lumbar
- ☐ General

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: _____