

Kessler Institute for Rehabilitation Pt Intake Form

Office Use Only

Intake Date:	History #	M R #	IP Case Manager:
Rec By:	Hospital Name:	Past Patient: <input type="checkbox"/> Y <input type="checkbox"/> N	IP to OP D/C Date:
Diagnosis 1 (Desc/ICD9):	Diagnosis 2 (Desc/ICD9):	Date of surgery/Injury/Onset:	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> CRP <input type="checkbox"/> Other
			Do you use a WC? <input type="checkbox"/> Y <input type="checkbox"/> N

Patient Information

Patient Name: (First, MI, Last, - Sr., Jr., etc)			SS #: - -		
Address:		City:		State:	Zip Code:
Telephone: Alt Tele #:		Date of Birth (mm-dd-yyyy)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	
Date of Injury / Onset Date	Auto Related: <input type="checkbox"/> Yes - State? <input type="checkbox"/> No	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Adjustor Name & Telephone #:		

If Workers Comp, was accident with present Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who was employer? Occupation:	If Auto Accident: Date of Accident: Type of Accident: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> ob <input type="checkbox"/> Fall <input type="checkbox"/> Other
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Do you have Medicare? No Yes **Do you have NJ Medicaid?** Yes package A, B, C or D? No
Are you currently receiving Home Health Services? No Yes
 If Yes, name of agency & what type of Home Health Services are you receiving?
 If No, have you received services in past 60 days Yes No Last date of service:
 Were you ever treated for Out Patient Physical Therapy before? No Yes Was it the same diagnosis? Yes No
 Are you currently residing in a Skilled Nursing Facility? Yes No If yes, Name of Facility?
 If Yes, are you on/in the "Medicare Unit"? Yes No

Primary Insurance Information

Name of Insurance Company:	Policy or Claim #:	Group # / Policy Holders Employer:
Policy Holder Name:	Date of Birth:	Social Security #
Insurance Company Telephone #:	Policy Holders Work Phone #:	Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other

Secondary Insurance Information (Backup if Auto, Workers Comp. or Litigation)

Name of Insurance Company:	Policy or Claim #:	Group # / Policy Holders Employer:
Policy Holder Name:	Date of Birth:	Social Security #
Insurance Company Telephone #:	Policy Holders Work Phone #:	Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other

Employer Information – Required for all WC patients

Employer Name:	Employer Phone #:	Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student
Address:	City:	State: Zip Code:

Emergency Contact Information

Contact Name:	Phone #	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Other
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Physician Information

Name of Referring Physician:	Telephone #:
Address:	City: State: Zip Code:

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Services: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> CRP <input type="checkbox"/> Other	Schedule: IE date / time: <input type="checkbox"/> M <input type="checkbox"/> TU <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	Therapist: _____ Comments / Level
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I acknowledge that the above information is correct. Date: _____ Signature: _____

If you would like to receive Kessler news, announcements and healthy tips, please include your e-mail address:
 _____ (Your email address will not be shared)