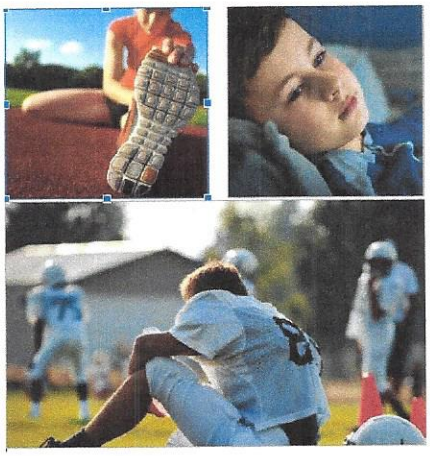
THE CONCUSSION RECOVERY CLINIC

An Interdisciplinary Clinic in a University Setting
Franklin Pierce University
670 North Commercial St.
3rd Floor, Center Tower
Manchester, NH 03110



PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: ____/____/____ Today's Date: ____/____/____ Date of Injury: ____/____/____

Parent/Guardian:_____

Home Address: _____

City: _____ State: _____Zip:_____

Phone: (H)_____ (W)_____ (C)_____

E-mail:_____

How did injury occur_____

Diagnosis: _____ By whom?_____

Was imaging done (xray, MRI): yes_____ no_____ Results:_____

Description of symptoms:_____

Referral for this Evaluation:_____

Patient's Physician: _____

Address: _____ Phone: _____

Other physicians seen (Orthopedist, audiologist, etc):_____

Address: _____ Phone: _____

Is Your Child Currently Receiving Speech, Physical or Occupational Therapy elsewhere? Yes No

Related Medical History:_____

Special Equipment Needs: _____

Special Medical Needs (Allergies, etc): _____

INSURANCE INFORMATION

Person Responsible for Payment: _____

Primary Insurance: _____

Address: _____

ID#: _____

Group#: _____

Name of Subscriber: _____ Employed By: _____

Secondary Insurance: _____

Address: _____

ID#: _____

Group#: _____

Name of Subscriber: _____ Employed By: _____

Medicaid#: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

I give permission for IT'S ABILITY, to evaluate and treat my child, to submit claims to the above named insurance carrier(s) for my child's physical therapy services and authorize the release of any medical information to process this claim. I also authorize payment of medical benefits to IT'S ABILITY for physical therapy services.

Parent/Guardian Signature: _____ Date: _____/_____/_____

THANK YOU!!

IT'S ABILITY
Pediatric Physical Therapy

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