



**WESTLAKE SPORTS THERAPY INC.**

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell #: \_\_\_\_\_  
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Referred by : \_\_\_\_\_ Email: \_\_\_\_\_

**Responsible Party (If different for patient)**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell #: \_\_\_\_\_  
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Email: \_\_\_\_\_

**Information about your symptoms/injury:**

What is your major area of complaint? \_\_\_\_\_  
When did this problem start? \_\_\_\_\_  
How did this problem occur (specific activities)? \_\_\_\_\_  
What actions increase the pain? \_\_\_\_\_  
Are you currently taking any medications for this problem? \_\_\_\_\_  
Are you seeing any other Doctors for this specific complaint? \_\_\_\_\_  
Please list any surgical operations: \_\_\_\_\_

If your treatment in the office today is related to work Injury or an Auto Injury, please notify our front desk.

Physical Therapy - Chiropractic - Massage Therapy - Personal & Athletic Training