VAULT
PHYSICAL THERAPY

Name: _____ DOB: _____

SSN: _____ Address: _____

Primary Phone: _____ Email: _____

What Insurance do you use? _____ Insurance Id:_____

Insurance holder (if not self): _____ DOB of Insurance holder: _____

Primary Care Provider: _____ Referring Physician: _____

Emergency Contact: _____

**Previous Medical History**

Previous Surgeries:

_____

_____

Current Medications:

_____

_____

Medical conditions therapist should be aware of:

_____

_____

info@GoVaultPT.com 208-413-7062 (office) 833-850-1887 (fax)
www.GoVaultPT.com 615 21st St. Lewiston, ID 83501

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Primary area of concern for treatment at this time:

_____

_____

_____

How long have you been in pain?

_____

_____

What are your goals for treatment?

_____

_____

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