Watson Wellness
Integrative Physical Therapy

Client Registration

- Client Information

Name_____ Email Address_____ Home/Cell Phone_____

Address_____ City_____ State_____ Zip_____

Social Security Number_____ Date of Birth_____ Marital Status_____

Place of Employment_____Occupation_____Phone_____

Address_____ City_____ State_____ Zip_____

Emergency Contact_____ Phone_____ Relationship_____

Who referred you to Watson Wellness?_____ Phone_____

Who is your Primary Care Physician?_____ Phone_____

- Spouse or Legal Guardian Information- If same as above please skip to next section.

Name_____ Email Address_____ Home/Cell Phone_____

Address_____ City_____ State_____ Zip_____

Social Security Number_____ Date of Birth_____ Marital Status_____

Place of Employment_____Occupation_____Phone_____

Address_____ City_____ State_____ Zip_____

- If your treatment is covered under Worker's Compensation, please fill out the section below.

Worker's Compensation Carrier_____ Phone_____

Contact Person_____ File Number_____ Date of Injury_____

Address_____ City_____ State_____ Zip_____

- If your treatment is due to an accident other than Worker's Compensation, please fill out the section below.

Is this related to an auto accident? Yes No Date of auto accident_____ State of auto accident_____

Is this related to other accident or injury? Yes No Date of accident or injury_____

Is there an attorney involved? Yes No Name_____ _____Phone_____

Client Signature_____ Date_____