



SALEM SPORTS & SPINE
PHYSICAL THERAPY

CLIENT INFORMATION

Name : _____ Date: _____

Date of Birth: _____

E-mail: _____

Address: _____

City _____ **State** _____ **Zip** _____

Phone: (H) _____ **cell#:** _____

(W) _____ **best time :** _____

EMERGENCY CONTACT: _____

Phone: w: _____ **cell:** _____

Medical Doctor: _____ **phone:** _____

Last Seen: _____

****I am aware that Salem Sports & Spine is a fee for service business and payment is expected at the time of service. A \$25.00 charge will be applied to any returned check. Missed appointments will be charged in full.**

Client signature

Date