
*Patient Intake Form - Recuperative Care*

**Patient Information**

Full Name: _____

Date of Birth: _____ Age: _____

Phone Number: _____

Address: _____

Emergency Contact Name: _____ Phone: _____

**Medical History**

Primary Diagnosis: _____

Current Medications: _____

Allergies: _____

Past Surgeries/Hospitalizations: _____

**Current Health Status**

Reason for Admission: _____

Symptoms/Concerns: _____

Mobility/Fall Risk: Yes [ ] No [ ]

Dietary Restrictions: _____


**Insurance & Provider Information**

Primary Insurance: _____

Policy Number: _____

Primary Care Provider: _____

Referring Agency (if applicable): _____

**Consent & Acknowledgment**

I acknowledge that the information provided is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Authorized Representative (if applicable): _____