

**HORIZON REHABILITATION PATIENT DATA SHEET**

**First:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** Male  Female

**Physical Address:** \_\_\_\_\_ **Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

| <b>Phone Numbers:</b> | <b>OK To Call</b>        | <b>Best Time To Call</b> |
|-----------------------|--------------------------|--------------------------|
| Home: _____           | <input type="checkbox"/> | _____                    |
| Work: _____           | <input type="checkbox"/> | _____                    |
| Cell: _____           | <input type="checkbox"/> | _____                    |

**May we send you text messages for your appointment reminders to the number(s) listed above?**  Yes  No

**May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above?**  Yes  No

**By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information**

**May we send you emails relating to your care with us?**  Yes  No  
**By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.**  
**Email:** \_\_\_\_\_

**Preferred language:** \_\_\_\_\_ **Interpreter required?**  Yes

**Date of Injury:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_  
**Injury Area:** \_\_\_\_\_ **Auto or Work Accident:**  Auto  Work  N/A

**State Where Accident Occured:** \_\_\_\_\_  
**Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days?**  Yes  No  
**Are you currently receiving or have you received other therapy services in the last 60 days?**  Yes  No

**Marital Status:**  
 Married  Single  Divorced  Widowed  Separated  Unknown

**Student Status:**  
 Full-Time  Part-Time  None

**EMPLOYMENT STATUS**

**Employment Status:**

Active Military    Full-Time    None    Part-Time    Retired    Self Employed

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**How did you hear about us?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physician      | <input type="checkbox"/> Hospital               | <input type="checkbox"/> Marketing Ad - Print               |
| <input type="checkbox"/> Employer       | <input type="checkbox"/> Cross Referral         | <input type="checkbox"/> Marketing Ad - TV                  |
| <input type="checkbox"/> Case Manager   | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard           |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney               | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor       | <input type="checkbox"/> Self                   | <input type="checkbox"/> Marketing Ad - Facebook            |
| <input type="checkbox"/> School         | <input type="checkbox"/> Screens - Open Houses  | <input type="checkbox"/> Marketing Ad - Other _____         |

Specify if other : \_\_\_\_\_

**Note: Please provide us with the most updated information below.**

**EMERGENCY AND OTHER CONTACTS**

| Name | Phone | Work | Cell | Fax | Type |
|------|-------|------|------|-----|------|
|      |       |      |      |     |      |
|      |       |      |      |     |      |
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|      |       |      |      |     |      |

**DISCLOSURE OF MEDICAL RECORDS**

I authorize the following individuals to have access to my medical and billing records:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



# Medical History Form

|  |   |   |      |
|--|---|---|------|
| Patient Name:  |   | Today's Date:   |      |
| Referring Physician:   |   | Date of Birth:  | Age: |
| Primary Care Physician:  |   | Date of Injury or Onset:  |      |
| Date of Next Physician Appointment:  |   |   |      |
| Reason for Therapy:  |   |   |      |
| Cause of Injury or Onset: <input type="checkbox"/> Accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other:      If Other, please explain:   |   |   |      |
| Have you been hospitalized for the present condition? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, date:  |   |   |      |
| Did you have surgery for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, date:<br>If Yes, surgery type:  |   |   |      |
| Are you currently receiving any other care for the condition mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, please describe:   |   |   |      |
| Have you ever received therapy in the past for the condition mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, date:<br>Describe previous treatment:  |   |   |      |
| Previous Treatment: <input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful  |   |   |      |
| Have you fallen in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, how many times?      If Yes, were you injured? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Do you feel unsteady when standing or walking? <input type="checkbox"/> Yes <input type="checkbox"/> No      Do you worry about falling? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |      |
| What are your personal goals/outcomes you hope to achieve from therapy?  |   |   |      |
| Describe your general health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor   |   | Do you smoke or use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No |      |
| DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)   |   |   |      |
| <input type="checkbox"/> Allergies <input type="checkbox"/> Latex <input type="checkbox"/> Other   | <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Kidney Problems  |      |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Epilepsy or Seizure Disorder   | <input type="checkbox"/> Metal Implants   |      |
| <input type="checkbox"/> Anxiety or Panic Disorders  | <input type="checkbox"/> Fainting   | <input type="checkbox"/> MRSA   |      |
| <input type="checkbox"/> Arthritis <input type="checkbox"/> OA <input type="checkbox"/> RA   | <input type="checkbox"/> Fatigue or Weakness  | <input type="checkbox"/> Multiple Sclerosis   |      |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Fever or Chills  | <input type="checkbox"/> Nausea / Vomiting  |      |
| <input type="checkbox"/> Use of Blood Thinners   | <input type="checkbox"/> Fractures  | <input type="checkbox"/> Osteoporosis   |      |
| <input type="checkbox"/> Bowel or Bladder Disorder   | <input type="checkbox"/> Headaches  | <input type="checkbox"/> Pacemaker  |      |
| <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Head Injury or Concussion  | <input type="checkbox"/> Parkinson's Disease  |      |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Hearing Impairment   | <input type="checkbox"/> Peripheral Vascular Disease                                  |      |
| <input type="checkbox"/> Chronic Cough   | <input type="checkbox"/> Heart Disease or Heart Attack  | <input type="checkbox"/> Respiratory or Breathing Problems                            |      |
| <input type="checkbox"/> COPD  | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Ringing in Ears  |      |
| <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> Hernia   | <input type="checkbox"/> Sexual Dysfunction   |      |
| <input type="checkbox"/> Currently Pregnant  | <input type="checkbox"/> Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low                  | <input type="checkbox"/> Skin Abnormalities   |      |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT)  | <input type="checkbox"/> HIV or AIDS  | <input type="checkbox"/> Stroke or TIA  |      |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Hypoglycemia   | <input type="checkbox"/> Thyroid Problems   |      |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II   | <input type="checkbox"/> Hypersensitivity to Hot or Cold  | <input type="checkbox"/> Tuberculosis   |      |
| List any other medical problems and explain:   |   |   |      |

# Medical History Form

## Medication List

| Name of Medication   | Dosage | Frequency |   |
|--|--------|-----------|---|
| <input type="checkbox"/> Check Box if Medication List provided separately.   |        |           |   |
| 1.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 2.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 3.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 4.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 5.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 6.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 7.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 8.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 9.   |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 10.  |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 11.  |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| 12.  |        |           | <input type="checkbox"/> Injection <input type="checkbox"/> Oral<br><input type="checkbox"/> Topical <input type="checkbox"/> Other |
| <b>Over the Counter Medications (check all that apply):</b> <input type="checkbox"/> Aspirin/Ibuprofen <input type="checkbox"/> Antacids <input type="checkbox"/> Sleeping Aids <input type="checkbox"/> Cold Medicine: <input type="checkbox"/> Cough Medicine <input type="checkbox"/> Allergy Relief <input type="checkbox"/> Laxative <input type="checkbox"/> Diet Pills <input type="checkbox"/> Vitamins/Herbal Supplements <input type="checkbox"/> Other: |        |           |   |

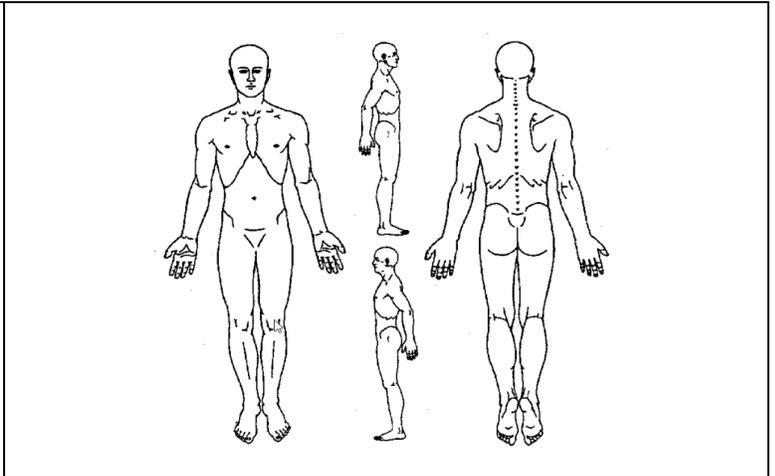
**Pain Scale**  
Rate the severity of your pain by circling a box on the following scale.

No Pain Worst Pain

|   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

**On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.**

**KEY:**  
 A = Aching      B = Burning      N = Numbness  
 P = Tingling    S = Stabbing    O = Other



|                                 |              |
|---------------------------------|--------------|
| <b>Signature of Patient:</b>    | <b>DOB:</b>  |
| <b>Printed Name of Patient:</b> | <b>Date:</b> |