TODAY'S DATE	HORIZONS	OFFICE USE ONLY

PATIENT INFORMATION

FIRST NAME	LAST NAME	MI	NICKNAME	GENDER	DATE OF BIRTH	STUDENT: FT/ PT

HOME ADDRESS	CITY/ STATE	ZIP CODE

MARITAL STATUS	EMPLOYER NAME	RETIRED	SOCIAL SECURITY NUMBER

WORK ADDRESS	CITY/ STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE	MAY WE LEAVE MESSAGES?

EMAIL ADDRESS	EMERGENCY CONTACT AND PHONE NUMBER

INSURANCE INFORMATION Please fill out if insurance is not in patient's name

PRIMARY INSURANCE NAME	NAME OF SUBSCRIBER	SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SOCIAL SECURITY NU

SUBSCRIBER RELATIONSHIP TO PATIENT	SUBSCRIBER PHONE NUMBER	SUBSCRIBER EMPLOYER

SUBSCRIBER ADDRESS	CITY/ STATE	ZIP CODE

CASE INFORMATION

NATURE OF PROBLEM	CAUSE OF PROBLEM	

REFERRING PHYSICIAN	RETURN TO DOCTOR DATE	COMMENTS

PRIMARY CARE PHYSICIAN	RETURN TO DOCTOR DATE	COMMENTS

REASON FOR TODAY'S VISIT

PLEASE DESCRIBE REASON FOR VISIT

INJURY OR ONSET DATE	SURGERY	SURGERY DATE	COMMENTS

HISTORY OF FALLS	DATES, INJURIES, TYPES OF FALLS	COMMENTS

DESCRIBE ACTIVITIES THAT CAUSE YOU DISCOMFORT: SELF CARE; ACTIVITIES OF LIVING(cooking, cleaning, driving); WORK; WALKING; MOBILITY

Cause of pain or injury:

Automobile accident	Surgery	Another party responsible
Fall	Employment injury	Other Accident
Abuse	Sports injury	None of the above

OCCUPATION	DESCRIPTION

STATUS: full time, part time, light duty, retired, etc	DATES OFF WORK OR COMMENTS

Please continue on reverse side of form

MAIN COMPLAINTS

MAIN COMPLAINTS	RESTRICTIONS
PAIN ALLEVIATORS: medication, position, heat, ice, etc	COMMENTS

PAIN SCALE: 0=NONE; 5= MODERATE; 10 = EXTREME

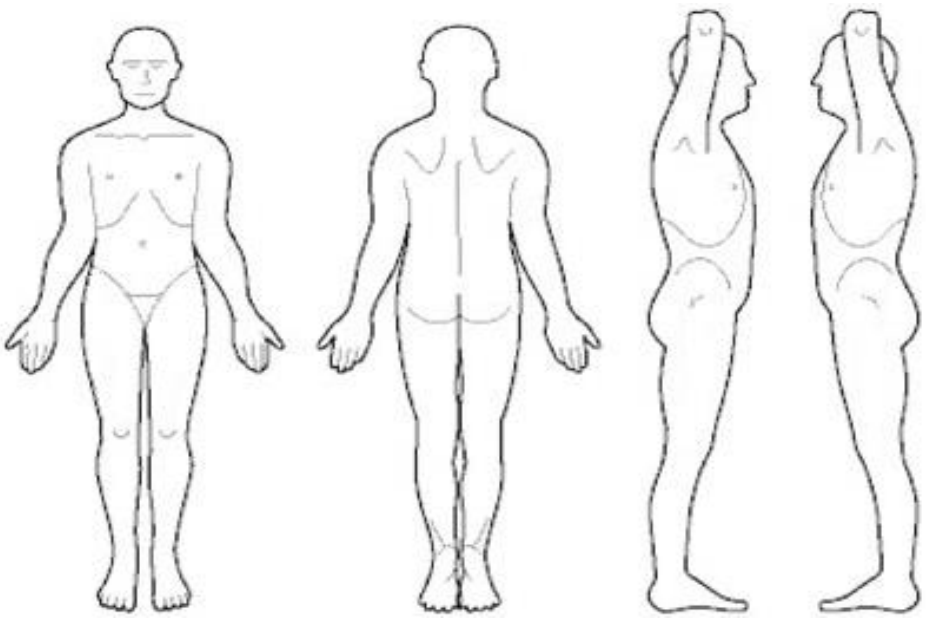
AT WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10

PAIN DESCRIPTION: burning, sharp, dull, achy, throbbing, shooting, numbness, tingling	PAIN LOCATION

Please draw in your symptoms on the diagram below.

PAIN with XXX NUMBNESS with OOO TINGLING with ///

R Front L L Back R R L



DIAGNOSTIC TESTING: X-RAYS, MRI CAT, etc.

MEDICAL HISTORY

Do you currently or have you in the past had any of the following medical conditions?

- ☐ osteoarthritis
- ☐ Heart condition
- ☐ Diabetes
- ☐ allergies
- ☐ surgical history
- ☐ previous therapy
- ☐ fractures
- ☐ kidney disease
- ☐ osteoporosis
- ☐ fatigue
- ☐ stroke/TIA
- ☐ weight loss
- ☐ substance abuse
- ☐ bowel/bladder
- ☐ current pregnancy
- ☐ anxiety
- ☐ lung condition
- ☐ blood disorder
- ☐ cancer
- ☐ depression
- ☐ fever/ chills
- ☐ headaches
- ☐ cholesterol
- ☐ blood pressure
- ☐ infections
- ☐ psychological
- ☐ smoking history
- ☐ MS/ Parkinsons
- ☐ dizziness
- ☐ other

Have you ever hit your head? YES NO

Please explain all checked items

MEDICATION

NAME REASON

What are your personal goals/ outcomes you hope to achieve from therapy?

Do you have anything artificial? (stents, joints, IUD, shunts)

Have you had therapy at Horizons in the past?

How did you hear about us?

NO CODE (DNR) FULL CODE circe one

Have you had Physical Therapy this year? YES NO

Have you had chiropractic this year? YES NO