



Authorization for Treatment

I hereby consent to and authorize all physical therapy treatments at Horizon Physical Therapy.

Signature _____ Date _____

Must be 18 years or older to sign.

Financial Agreement

I understand and agree that I am responsible for payment for services performed at Horizon Physical Therapy. I will pay upon demand, all charges that are my responsibility. I authorize all payments be made from my insurance company to Horizon Physical Therapy and I am responsible for all charges not paid by my insurance company. I authorize Horizon Physical Therapy to provide information necessary to secure payment of benefits. Please initial _____

Use of Protected Health Information

I have been provided with a Notice of Information Practices. I understand that Horizon Physical Therapy may disclose my personal health information for the purpose of carrying out treatment and obtaining payment. I hereby consent the use and disclosure of my personal health information as described in the Notice of Information Practices. I understand I can revoke this consent by notifying the practice in writing at any time. Please initial _____

Patient Signature _____ Date _____

Thank you for your assistance.



Functional Questionnaire

Please select the best answer for each category.

Sleeping

- My sleep is **severely** disturbed (5-7 hours of sleeplessness).
- My sleep is **greatly** disturbed (3-5 hours sleeplessness).
- My sleep is **moderately** disturbed (2-3 sleeplessness).
- My sleep is **mildly** disturbed (1-2 hours sleeplessness).
- I have no trouble sleeping.

How many times per night do your symptoms wake you up? _____

Sitting

- Symptoms prevent me from sitting at all.
- Symptoms prevent me from sitting for more than **10** minutes.
- Symptoms prevent me from sitting for more than **30** minutes.
- Symptoms prevent me from sitting for more than **60** minutes.
- I can sit as long as I want, but it gives me extra symptoms.
- I can sit as long as I like.

Standing

- Symptoms prevent me from standing at all.
- Symptoms prevent me from standing for more than **10** minutes.
- Symptoms prevent me from standing for more than **30** minutes.
- Symptoms prevent me from standing for more than **60** minutes.
- I can stand as long as I want, but it gives me extra symptoms.
- I can stand as long as I like.

Walking

- I am in bed most of the time.
- I can only walk using a cane/crutches/walker.
- Symptoms prevent me from walking more than $\frac{1}{4}$ mile.
- Symptoms prevent me from walking more than $\frac{1}{2}$ mile.
- Symptoms prevent me from walking more than **1** mile.
- Symptoms do not prevent me walking any distance.

Reaching

- I cannot reach my hand above waist level without increased symptoms.
- I cannot reach to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
- I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
- I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
- I can reach to a high shelf to place an empty cup with some increased symptoms.
- I can reach to a high shelf to place an empty cup without increased symptoms.

Recreation

- I cannot do any recreational activities
- I can hardly do any recreational activities because of increased symptoms.
- I am able to engage in a few of my usual recreational activities because of increased symptoms.
- I am able to engage in most, but not all of my usual recreational activities with some increased symptoms.
- I am able to engage in all my recreational activities with some increased symptoms
- I am able to engage in all my recreational activities without increased symptoms



Patient Information Form

Patient Information

Today's Date _____
Referring Physician _____ Primary Physician _____
Last Name _____ First Name _____ Middle Initial _____
Address _____
City, State Zip _____
Social Security Number _____ Date of Birth _____ Gender: Male Female
Home Phone _____ Mobile Phone _____ Work Phone _____
Email Address: _____
for use by Horizon PT only will not be shared with any outside agencies

Employer _____ Work Address _____
Are you here because of an accident? Yes No If yes, explain _____ Date of Injury _____
Were you injured at work? Yes No If yes, explain _____ Date of Injury _____

Policy Holder Information

Relationship to Patient _____
Last Name _____ First Name _____ Middle Initial _____
Address _____
City, State Zip _____
Social Security Number _____ Date of Birth _____ Gender: Male Female
Home Phone _____ Mobile Phone _____ Work Phone _____
Employer _____ Work Address _____

Insurance Information

Primary Insurance

Policy Holder _____ Patients Relationship to Policy Holder _____
Policy Holder Date of Birth _____
Primary Insurance _____ Phone _____
Address _____
City, State Zip _____

Emergency Contact

Name _____ Relationship _____
Home Phone _____ Work Phone _____ Mobile Phone _____

How did you hear about Horizon Physical Therapy? _____

For office use only

DX Code: _____ Therapist: _____

HORIZON

PHYSICAL THERAPY PC

Patient Health History

Patient Name: _____ Date: _____

Next Scheduled Doctor Appointment: _____

Condition	Yes	No	Date	Condition	Yes	No	Date
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____							

Diagnostics	Yes	No	Date	Findings
X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nerve Studies	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Procedures/Surgery	Yes	No	Date	Please Describe
Orthopedic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
C-Section	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Child Birth	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Previous Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Symptoms	Yes	No	Date	Location
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Aching	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sharp	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Please mark your pain on average on the line below.

0 1 2 3 4 5 6 7 8 9 10
 No Pain ER Visit

Please mark on the diagram where your symptoms are located.

