Horn and Associates in Rehabilitation, PLLC

New Client Questionnaire (Adult)

Client Information

Name:________________________________ Date of Birth:____________SSN____________

Address:____

Phone Number:_________________________ Email:_________________________________

Occupation:___________________________ Employer:______________________________

Physician's Name:______________________ Diagnosis:_____________________________

Emergency Contact:_____________________ Phone Number:__________________________

Medical History

Describe applicable medical history (illnesses, allergies, surgeries, injuries, accidents, medications):____

____

____

____

Please circle if you have ever had any of the following:

Arthritis	Broken Bones/Fractures	Osteoporosis
Blood Disorder	Circulation/Vascular Problems	Heart Problems
High Blood Pressure	Respiratory Problems	Stroke
Diabetes	Head Injury	Depression
Gastrointestinal Disorder	Multiple Sclerosis	Anxiety
Muscular Dystrophy	Parkinson's Disease	Seizures
Developmental Disorder	Thyroid Disorder	Cancer
Infectious Disease	Kidney Disorder	Skin Disorder
Autoimmune Disorder	Other:__________________________________	

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Circle if you have had any of the following symptoms:

Chest Pain	Heart Palpitations	Cough
Hoarseness	Shortness of Breath	Dizziness/Fainting
Coordination Problems	Weakness in Arms/Legs	Loss of Balance
Difficulty Walking	Joint Pain/Swelling	Pain at Night
Difficulty Sleeping	Loss of Appetite	Nausea/Vomiting
Difficulty Swallowing	Bowel Problems	Weight Loss/Gain
Urinary Problems	Fever/Chills/Sweating	Headaches
Hearing Problems	Vision Problems	Panic Attacks

Other:____

Family and Social History

List applicable information regarding marital status, spouse's name, children's name(s) and age(s):____

____

____

Describe current work status, including physical and/or emotional demands of occupation. If not working, how long has it been since you have been employed? ________________________

____

____

Describe overall activity level (sedentary, light, moderate, heavy, very heavy). Describe any regular sports/exercise activities.____

____

Education: List applicable information regarding schools attended, degrees earned:

____

____

Describe any special interests/hobbies:____

____

2412 Greatstone Point
Lexington, Kentucky 40504

(859) 224-4081 (ph.)
(859) 224-4082 (fax)

4127 Todds Road
Lexington, Kentucky 40509

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Therapy Needs/Concerns:

Describe reason for seeking therapy:____

____

Describe the issue (onset, recent changes, pain intensity, variability on daily/weekly basis, etc.):

____
____
____

What do you think caused this issue? What have you done to help with this issue?

____
____
____

Have you had any special tests regarding this issue (e.g., MRI, CT scan, swallow study, X-ray)? If so, do you know the results?____

____

Have you received therapy before? If so, what discipline(s), when, where, and goals: ________

____
____
____

Have you sought any other professional assistance with this issue? If so, please provide name, type of professional, and any diagnoses provided:_____________________________________

____
____

What are your concerns during the school/work environment?:____________________________

____

What are your concerns during daily activities?:______________________________________

____

Please use this space to provide any other information regarding your reason for seeking therapy:____
____
____
____