Therapy Achievements, LLC

The Rehab Specialists

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Date: _____/_____/_____ Are you currently receiving home health care? (Circle one**) Yes or No**

Patient Name: _____ **Date of Birth:** ____/____/____

Address: _____

Home Phone: (_____) _____ Cell: (_____) _____ **Work**: (_____) _____

Email address: _____

Preferred method of Appointment reminders: Text / Call / Email

Primary Insurance: _____ **Contract Number**: _____

Subscriber Name: _____**Date of Birth:** _____ **(circle) Self Spouse Parent**

Secondary Insurance: _____ **Contract Number**: _____

Subscriber Name: _____ **Date of Birth:** _____ **(circle) Self Spouse Parent**

Emergency Contact Info:

Name: _____ Relationship: _____

Address: _____

Home phone: (____) _____ Cell phone: (____) _____

Do you have problems with:

____ Balance or walking _____ Strength or Endurance _____ Movement or Flexibility _____ Scar Tissue

____ Pain ____ Swelling _____ Vision _____ Thinking or Memory _____ Coughing or Choking

_____ Functional Living Skills Please Describe: _____

_____

Please List Your Physicians below:

Family/ Primary Care _____

Neurologist: _____

ENT: _____

Orthopedic or Vascular: _____

Oncologist &
Radiation Oncologist: _____

Other: _____

Please List Your Medications below

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____