Saguaro Rehabilitation and Aquatic Therapy, LLC.

PATIENT INFORMATION

Demographics

Last Name:_____ First Name:_____ MI:_____ DOB:_____

Address:_____ Lot/Apt#:_____ City:_____ State:_____ Zip:_____

County:_____ E-Mail Address (Optional):_____

Home Phone:_____ Cell Phone:_____ Preference: Home☐ Cell ☐

(May we leave a message about appointments on the phone numbers you provided?) Yes☐ No☐

Marital Status: Married☐ Single☐ Divorced☐ Widowed☐ Gender: Male☐ Female☐ Last 4 of SS#:_____

Race: Caucasian ☐ African American(Black)☐ Asian ☐ American Indian or Alaska Native☐ Native Hawaiian or Other ☐

Pacific Islander ☐ Two or More Races ☐ Decline to Specify ☐

Ethnicity: Hispanic/Latino/Spanish Origin Yes ☐ No ☐ Decline to Specify ☐

Secondary Address: (If Applicable)

Address:_____ Lot/Apt#:_____ City:_____ State:_____ Zip:_____

Home Environment

Live Alone: Yes☐ No☐ If No, who lives with you: _____ Relationship:_____
Are you in Assisted Living Yes ☐ No☐ In a Group Home Yes☐ No☐ In a Long-Term Facility Yes☐No ☐
Are you homeless Yes☐ No☐ Do you have Pets Yes☐No☐ Stairs/steps Yes☐No ☐Handrails Yes☐No☐
Do you have any barriers to Healthy Living Yes☐No☐If yes please explain _____

Medical Information

Referring Physician:_____ Specialty:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Describe Complaint:_____

Date of Onset:_____ Diagnosis:_____

Recent Hospitalization, Nursing Home, or Home Healthcare: Yes☐No☐ Facility Name:_____

List Surgeries & Approximate Dates:_____

Current Medical Equipment or Supplies Required:_____

List Current Medications:_____

Any Barriers to Treatment: Chronic Health Conditions ☐ Transportation ☐ Legal ☐ Nutrition/Diet ☐ Housing ☐
Emotional/Mental ☐Family ☐ Memory ☐ Balance ☐ Financial ☐ Drugs/Alcohol ☐ Scheduling ☐
Physical Handicap ☐ Pain ☐
Other ☐ \Please Explain_____