FYZICAL
Therapy & Balance Centers

CLIENT INFORMATION

Last Name:_____First Name:_____Middle Initial:_____
Address:_____Apt:_____
City:_____State:_____Zip:_____
Date of Birth:_____Sex:_____Social Security #:_____
Home Phone #:_____ Cell #:_____ E-Mail _____
Preferred Contact Method: PHONE ☐ EMAIL ☐ TEXT ☐
Emergency Contact:_____Phone#:_____Relationship:_____
Primary Doctor:_____ Referring Doctor:_____
Have you had any Home Health in the past 12 Months: YES ☐ NO ☐ If yes, Company:_____
Have you had any physical, occupational, or speech therapy this year? YES ☐ NO ☐
How did you hear about FYZICAL? _____

IF CLIENT IS A MINOR / ALTERNATIVE PARTY RESPONSIBLE

Responsible party for bill if other than client:_____Relationship:_____
Responsible party's address (If different than above):_____
Date of Birth: _____ Social Security:_____

Consent for Treatment:
I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information:
I authorize FYZICAL to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____

Consent to Obtain Medical Information:
I authorize FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, CAT scans, and MRI reports, along with Physician's documentation.

Assignment of Insurance Benefits:
I hereby authorize payment to be made directly to FYZICAL

Guarantee of Payment:
I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

Cancellation No show policy:
I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and effects other patients as well. Appointments without sufficient notice (Less than 24 hours) will be charged a $25 fee. A no-show without any notice will incur a $35 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as a patient.

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of FYZICAL's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information.
I have received a copy of the patient's rights and responsibilities handout: YES ☐ NO ☐

Client/Responsible Party Signature: _____Date:_____
Legal Representation (If applicable):Name:_____Signature:_____

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CLIENT HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____/_____/_____

Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

Please tell us how long ago your condition started: _____

List tests or other interventions for this condition that you have had: _____

Please indicate the daily activities that you cannot perform: _____

Please indicate your level of functioning prior to the onset of this condition: _____

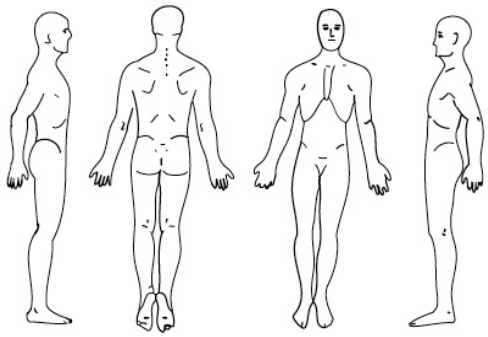
Please inform us of any environmental or living conditions that may have difficulties with: _____

Did you have surgery? ☐ No ☐ Yes Date ____/____/____ Procedure: _____

Please describe the nature of your symptoms (check **all** that apply):

- ☐ Vertigo
- ☐ Lightheadedness
- ☐ Imbalance
- ☐ Feeling "off"
- ☐ Ear Pressure/Pain
- ☐ Motion intolerant
- ☐ Migraine/Headaches
- ☐ Head Injury/Concussion
- ☐ Sharp Pain
- ☐ Dull (Pain) Ache
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Constant (76 – 100%)
- ☐ Frequent (51 – 75%)
- ☐ Occasional (26 – 50%)
- ☐ Intermittent (25% - or less)

Please Mark on the picture locations of pain



Level of symptoms at rest from 0 (No symptoms) to 10 (Unbearable symptoms) _____

Level of symptoms with activity from 0 (No symptoms) to 10 (Unbearable symptoms) _____

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Your symptoms are worse in: ☐ morning ☐ afternoon ☐night ☐ increased during the day ☐ same all day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Occupation _____ Has your work status changed because of this condition ☐ YES ☐ NO

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Cancer - Location: _____Date: _____
☐	☐	Tumor
☐	☐	Systemic Lupus
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Other _____
☐	☐	Tobacco - packs/day _____
☐	☐	Drug or Alcohol Dependence

Present: Weight _____ Height _____ft _____in.

Have you fallen in the last year? ☐ NO ☐ YES - If yes, how many? _____

Medication: (Name/Dosage/Frequency/Route Administered)

_____

_____

_____

_____

_____

_____

_____

****If you need additional room for medications please bring a separate document on your next visit**

Hospitalization/Surgical Procedures (list if not described elsewhere):

_____

_____

Do you have a Pace Maker: ☐ NO ☐ YES

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Please list all prescription medications, over the counter medications, herbal medications, vitamins and supplements that you are currently taking in the table below. Bring this completed list with you to your appointment.

Name	Dosage	Frequency (i.e. daily, weekly, etc.)	Route (i.e. oral, eye drops, nasal spray, etc.)

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Your Name: _____ DOB:_____Date:_____

The ACTIVITIES BALANCE CONFIDENCE (ABC) SCALE

For each of the following activities, please indicate you level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No confidence Moderately Confident Completely Confident

NOTE: If you are not currently performing the activity in question, try and IMAGINE how confident you would be if you HAD to perform the activity. Also, if you use an assistive device (walker, cane, etc.), you may rate it as if you were using that device.

*How confident are you that you will NOT lose your balance or become unsteady when you...

1. ...walk around the house? ____%
2. ...walk up or down the stairs? ____%
3. ...bend over and pick up a slipper from the front of a closet floor? ____%
4. ...reach for a small can off of a shelf at eye level? ____%
5. ...stand on your tip toes and reach for something above your head? ____%
6. ...stand on a chair and reach for something? ____%
7. ...sweep the floor? ____%
8. ...walk outside the house to a car parked in the driveway? ____%
9. ...get into or out of a car? ____%
10. ...walk across a parking lot to the mall? ____%
11. ...walk up or down a ramp? ____%
12. ...walk in a crowded mall where people rapidly walk past you? ____%
13. ...are bumped into by people as you walk through the mall? ____%
14. ...step onto or off of an escalator while you are holding onto a railing? ____%
15. ...step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
16. ...walk outside on icy sidewalks? ____%

FOR OFFICE USE ONLY: Scoring: _____ = _____ x100 = _____%

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Patient name: _____ Date:_____

Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. **Please do not skip any questions.**

1. Does looking up increase your problem?	Yes	Sometimes	No
2. Because of your problem, do you feel frustrated?	Yes	Sometimes	No
3. Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
4. Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or going to parties?	Yes	Sometimes	No
7. Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes	Sometimes	No
9. Because of your problem, are you afraid to leave home without having someone with you?	Yes	Sometimes	No
10. Because of your problem, are you embarrassed in front of others?	Yes	Sometimes	No
11. Do quick movements of your head increase your problem?	Yes	Sometimes	No
12. Because of your problem, do you avoid heights?	Yes	Sometimes	No
13. Does turning over in bed increase your problem?	Yes	Sometimes	No
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
15. Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
17. Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
18. Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
19. Because of your problem, is it difficult to walk around your house in the dark?	Yes	Sometimes	No
20. Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
21. Because of your problem, do you feel handicapped?	Yes	Sometimes	No
22. Has your problem placed stress on your relationship with family and friends?	Yes	Sometimes	No
23. Because of your problem, are you depressed?	Yes	Sometimes	No
24. Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
25. Does bending over increase your problem?	Yes	Sometimes	No

FOR OFFICE USE ONLY: *# of 'Yes'_____x4= _____* *Total= _____*

of 'Sometimes'_____x2= _____