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

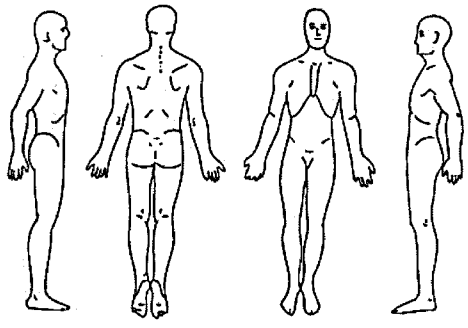
Name _____ Age _____ Date ____/____/____

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.)

Patient Name: _____ **Date:** _____

TMD Disability Index Questionnaire

Please check the one statement that best pertains to you (not necessarily exactly) in each of the following categories.

Section 1 - Communication (Talking)

____ (0) I can talk as much as I want without pain, fatigue or discomfort.
____ (1) I talk as much as I want, but it causes some pain, fatigue and/or discomfort.
____ (2) I can't talk as much as I want because of pain, fatigue and/or discomfort.
____ (3) I can't talk much at all because of pain, fatigue and/or discomfort.
____ (4) Pain prevents me from talking at all.

Section 2 - Normal Living Activities (Brushing Teeth/Flossing)

____ (0) I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
____ (1) I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
____ (2) I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
____ (3) I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
____ (4) I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

Section 3 - Normal Living Activities (Eating, Chewing)

____ (0) I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
____ (1) I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
____ (2) I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
____ (3) I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
____ (4) I must stay on a liquid diet because of pain and/or restricted opening.

Section 4 - Social/Recreational Activities (Singing, Playing Musical Instruments, Cheering, Laughing, Social Activities, Playing Amateur Sports/Hobbies, and Recreation, etc)

____ (0) I am enjoying a normal social life and/or recreational activities without restriction.
____ (1) I participate in normal social life and/or recreational activities but pain/discomfort is increased.
____ (2) The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instrument, singing).
____ (3) I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
____ (4) I have practically no social life because of pain.

Section 5 - Non-Specialized Jaw Activities (Yawning, Mouth Opening and Opening my Mouth Wide)

____ (0) I can yawn in a normal fashion, painlessly.
____ (1) I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
____ (2) I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
____ (3) Yawning and opening my mouth wide are somewhat restricted by pain.
____ (4) I cannot yawn or open my mouth more than two finger widths (2.8-3.2 cm) or, if I can, it always causes greater than moderate pain.

Page 1 Total: _____

Patient Signature: _____ **Date** _____

Therapist Signature: _____ **Date** _____

Patient Name: _____ **Date:** _____

TMD Disability Index Questionnaire

Section 6 - Sexual function (Including Kissing, Hugging and Any and All Sexual Activities to Which You Are Accustomed)

____ (0) I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face or jaw pain.
____ (1) I am able to engage in all my customary sexual activities and expression, but it sometimes causes some headache, face, or jaw pain, or jaw fatigue.
____ (2) I am able to engage in all my customary sexual activities and expression, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.
____ (3) I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.
____ (4) I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

Section 7 - Sleep (Restful, Nocturnal Sleep Pattern)

____ (0) I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
____ (1) I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aides.
____ (2) I fail to realize 6 hours restful sleep even with the use of pills.
____ (3) I fail to realize 4 hours restful sleep even with the use of pills.
____ (4) I fail to realize 2 hours restful sleep even with the use of pills.

Section 8 - Effects of Any Form of Treatment, Including, But Not Limited to, Medications, In-office Therapy, Treatment, Oral Orthotics (eg, Splints, Mouthpieces), Ice/Heat, etc.

____ (0) I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
____ (1) I can completely control my pain with some form of treatment.
____ (2) I get partial, but significant, relief through some form of treatment.
____ (3) I don't get "a lot of" relief from any form of treatment.
____ (4) There is no form of treatment that helps enough to make me want to continue.

Section 9 - Tinnitus, or Ringing in the Ear(s)

____ (0) I do not experience ringing in my ear(s).
____ (1) I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
____ (2) I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
____ (3) I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
____ (4) I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

Section 10 - Dizziness (Lightheaded, Spinning and/or Balance Disturbance)

____ (0) I do not experience dizziness.
____ (1) I experience dizziness, but it does not interfere with my daily activities.
____ (2) I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
____ (3) I experience dizziness, which causes a marked impairment in the performance of my daily activities.
____ (4) I experience dizziness, which is incapacitating.

Page 2 Total: _____

Total Score (Page 1 + Page 2): _____

$$\frac{\text{Total Score}}{\text{Total \# Possible}} = \text{\% Disability}$$

_____ % Disability

Patient Signature: _____ **Date** _____

Therapist Signature: _____ **Date** _____