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

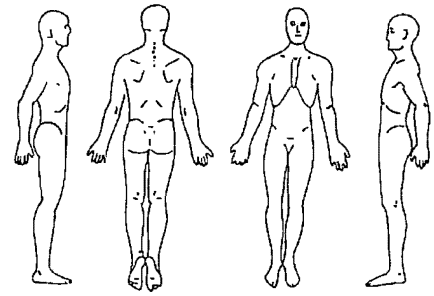
Name _____ Age _____ Date ____/____/____

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

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

Post-Concussion Symptom Scale (PCSS)

Please use the following scale to rate each symptom:

	None	Mild		Moderate		Severe	
Symptoms	0	1	2	3	4	5	6
Headache							
Nausea							
Vomiting							
Balance Problems							
Dizziness							
Lightheadedness							
Fatigue							
Trouble Falling Asleep							
Sleeping more than usual							
Sleeping less than usual							
Drowsiness							
Sensitivity to light							
Sensitivity to noise							
Irritability							
Sadness							
Nervous/anxious							
Feeling more emotional							
Numbness or tingling							
Feeling slowed down							
Feeling like "in a fog"							
Difficulty concentrating							
Difficulty remembering							
Visual problems							
Other							
Totals:							
Total Symptom Score:							

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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