Client Demographic Information

Today's Date:_____

FYZICAL Therapy & Balance Centers

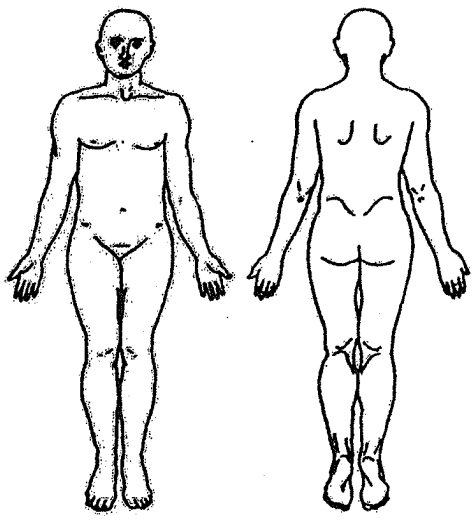
Name: _____ Date of Birth:_____
Phone Number: _____ Emergency Contact(Name and Phone): _____
Email: _____ _____
How did you hear about us? ☐ Doctor ☐ Friend ☐ Internet ☐ Other_____
How would you like to receive reminders about your appointment? ☐ Text ☐ Phone call ☐ Email
Occupation_____ Work status? _____
Dominant hand ☐ Right ☐ Left ☐ Ambidextrous

Have you fallen in the last year? ☐ Yes ☐ No If yes, were you injured? ☐ Yes ☐ No describe _____
How much physical activity or exercise per week? ☐ 30+ minutes 5+days/week ☐ 30+min 3-5 days/wk
☐ 30+min 1-3 days/wk ☐ less than 30 minutes 1-3 days/wk ☐ not regularly exercising ☐ Other _____
Are you interested in learning about how a medically based fitness program can safely optimize your health?
☐ Yes ☐ No
What daily activities are you having difficulty performing? _____
What are your goals for physical therapy? _____
Do you have difficulty hearing? ☐ Yes ☐ No Do you have hearing aids? ☐ Yes ☐ No

Symptom Questionnaire

What problem or issue brings you here? _____
How and when did it start? _____
Did you have surgery? ☐ Yes ☐ No Procedure: _____ Date of surgery? _____
What tests have you had? ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Bone scan ☐ Other _____
What treatments have you had? ☐ Physical Therapy ☐ Massage ☐ Chiropractic ☐ Other _____

Mark or shade the locations of your pain on the picture below



Please describe your pain or chief symptoms: (check all that apply)

☐ Vertigo, room spinning
☐ Light headedness
☐ Imbalance
☐ Ear pressure/pain
☐ Motion intolerance
☐ Headaches/migraine
☐ Head injury/concussion
☐ Tingling
☐ Burning
☐ Shooting
☐ Throbbing
☐ Dull pain / ache
☐ Sharp pain

Please describe the intensity and pattern of symptoms:

Symptoms are...
☐ Getting better
☐ Not changing
☐ Getting worse

Symptoms are worse...
☐ Morning
☐ Afternoon
☐ Night
☐ Constant

Activities/positions that increase symptoms_____
Activities/positions that decrease symptoms_____

Place marks on lines to indicate your level of pain/ symptoms
0= no pain/symptoms 5= symptoms cause you to stop activities 10= must go to hospital

Please rate your **CURRENT** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10

Please rate your **BEST** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10

Please rate your **WORST** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10

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Do you have a pacemaker? ☐ Yes ☐ No

Do you have any joint replacements or metal implants? ☐ Yes ☐ No Please list types and dates: _____

Chemotherapy ? ☐ Yes ☐ No Radiation ? ☐ Yes ☐ No

Recent night pain or fevers/ sweats ☐ Yes ☐ No

Depressed mood/anxiety? ☐ Yes ☐ No

New rashes / psoriasis? ☐ Yes ☐ No

bowel/bladder changes? ☐ Yes ☐ No

History of tobacco use? ☐ Never ☐ Yes ☐ Quit ☐ Current

Alcohol use? ☐ Yes ☐ No if Yes, drinks per week?_____

Do you have to rush to use the bathroom? ☐ Yes ☐ No

Cigarette packs/day _____☐ Cigar ☐ Pipe ☐ Chew

Do you leak urine, even a small amount? ☐ Yes ☐ No

WOMEN: Currently pregnant? ☐ Yes ☐ No Est. date of delivery_____ Number of pregnancies? _____

Number of vaginal deliveries? _____ Number of C-sections? _____Date of last menstrual period? _____

Hysterectomy? ☐ Yes ☐ No Date_____ Pelvic organ prolapse? ☐ Yes ☐ No Type _____

Medical History and Family History. 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. If you have a family history of a condition, check it in the FAMILY column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

CONDITION	PAST	PRESENT	FAMILY	CONDITION	PAST	PRESENT	FAMILY
Angina	☐	☐	☐	Systemic Lupus	☐	☐	☐
Chest pain	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Heart Attack	☐	☐	☐	Osteoarthritis	☐	☐	☐
Cardiac Problems	☐	☐	☐	Osteoporosis	☐	☐	☐
Peripheral neuropathy	☐	☐	☐	Blood clot	☐	☐	☐
Infectious diseases	☐	☐	☐	Fibromyalgia	☐	☐	☐
Lower limb swelling	☐	☐	☐				

Other Present or Past Medical Conditons:_____

Client Signature _____ Date_____

DIZZINESS HANDICAP INVENTORY

Name: _____ **Date:** _____

Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1. Does looking up increase your problem?	Yes	No	Sometimes
E2. Because of your problem, do you feel frustrated?	Yes	No	Sometimes
F3. Because of your problem, do you restrict your travel for business or recreation?	Yes	No	Sometimes
P4. Does walking down the aisle of a supermarket increase your problem?	Yes	No	Sometimes
F5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	No	Sometimes
F6. Does your problem significantly restrict your participation in social activities such As going out to dinner, going to the movies, dancing, or to parties?	Yes	No	Sometimes
F7. Because of your problem, do you have difficulty reading?	Yes	No	Sometimes
P8. Does performing more ambitious activities like sports, dancing, household chores Such as sweeping or putting away dishes increase your problem?	Yes	No	Sometimes
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes	No	Sometimes
E10. Because of your problem, have you been embarrassed in front of others	Yes	No	Sometimes
P11. Do quick movements of your head increase your problem?	Yes	No	Sometimes
F12. Because of your problem, do you avoid heights?	Yes	No	Sometimes
P13. Does turning over in bed increase your problem?	Yes	No	Sometimes
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	No	Sometimes
E15. Because of your problem, are you afraid people might think you are intoxicated?	Yes	No	Sometimes
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	No	Sometimes
P17. Does walking down a sidewalk increase your problem?	Yes	No	Sometimes
E18. Because of your problem, is it difficult for you to concentrate?	Yes	No	Sometimes

F19. Because of your problem, is it difficult for you walk around the house in the dark? Yes No Sometimes

E20. Because of your problem, are you afraid to stay home alone? Yes No Sometimes

E21. Because of your problem, do you feel handicapped? Yes No Sometimes

E22. Has your problem placed stress on your relationships with members of your family or friends? Yes No Sometimes

E23. Because of your problem, are you depressed? Yes No Sometimes

F24. Does your problem interfere with your job or household responsibilities? Yes No Sometimes

P25. Does bending over increase your problem? Yes No Sometimes

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Part II

Instructions: Put a check in the box that best describes you.

☐	**Negligible symptoms (0)**
☐	**Bothersome symptoms (1)**
☐	**Performs usual work duties but symptoms interfere with outside activities (2)**
☐	**Symptoms disrupt performance of both usual work duties and outside activities (3)**
☐	**Currently on medical leave or had to change jobs because of symptoms (4)**
☐	**Unable to work for over one year or established permanent disability with compensation payments (5)**

STOP HERE

	Yes		Sometimes		No	
P(7)	_____x4=____	+	_____x2=____	+	_____x0=____	**Physical Items**_____ **(28)**
E(9)	_____x4=____	+	_____x2=____	+	_____x0=____	**Emotional Items**_____ **(36)**
F(9)	_____x4=____	+	_____x2=____	+	_____x0=____	**Functional Items**_____ **(36)**

TOTAL_____
(max 100 pts)

The Activities-specific Balance Confidence (ABC) Scale

For each of the following activities, please indicate your 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 **completely confident**

"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 stairs? ____%
3. …bend over and pick up a slipper from the front of a closet floor ____%
4. …reach for a small can off a shelf at eye level? ____%
5. …stand on your tiptoes 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 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? ____%

FYZICAL
Therapy & Balance Centers

Patient Acknowledgement Form

Please Read and Initial:

_____ I consent to **evaluation and treatment** by FYZICAL Therapy and Balance Centers and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ The filling of insurance claims is a courtesy that we extend to our patients. **You will be responsible for any charges not reimbursed or contractually adjusted by your insurance company.** Should your claims not process as you expected or should you have any questions regarding your insurance plan benefits, Please contact your insurance company directly.

_____ I authorize the **release of information** acquired in the course of my treatment including by not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, other third party payers and/or the following (i.e spouse, family member, friend: _____)

_____ I realize that if I accumulate 3 no show or cancellation appointments, the physical therapist has the right to discharge me as a patient due to non-compliance.

_____ I authorize **phone, e-mail, and/or text messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ I have received and/or been offered a copy of this facility's **Notice of information/ Privacy Practices** has been provided to me.

_____ Medicare beneficiaries have an annual cap for combine therapy services including Physical, Occupational, and Speech Therapies.

_____ A $35.00 charge will be charged for any returned checks.

_____ Should a patient account become 60 days past due the account will be placed with a collection agency and a $35.00 collection fee will be charged.

_____ I hereby **assign** to FYZICAL Therapy and Balance Centers all payment for medical services rendered to myself or my dependants. **I understand I am responsible for any amount not covered by my insurance.**

_____ _____
Patient Signature Today's Date

_____ _____
Patient Legal Representative Today's Date