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 info1·mation 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) or a no-show without any notice will be charged a $50 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:_________________

Client Demographic Information   Today's Date:____________________

FYZICAL Therapy & Balance Centers

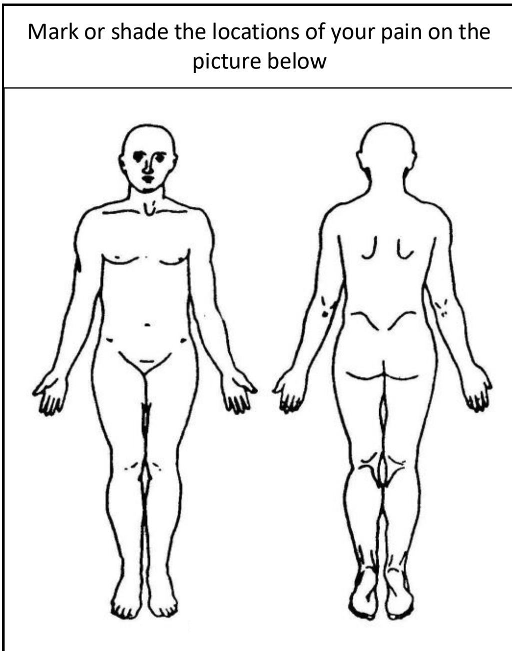
Name: ______________________________ Date of Birth:______________________________
Phone Number: ______________________________ Emergency Contact(Name and Phone): ______________
Email: ______________________________ ______________________________
How did you hear about us? ☐ Doctor ☐ Friend ☐ Internet ☐ 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

Client Demographic Information

Today's Date:___________________

Do you have a pacemaker? ☐ Yes ☐ No Do you have high blood pressure? ☐ Yes ☐ No What is usual BP? _______
Do you have any joint replacements or metal implants? ☐ Yes ☐ No Please list types and dates: ________________

Do you have a history of cancer or tumors? ☐ Yes ☐ No Please describe type and date: ________________
____ Chemotherapy ? ☐ Yes ☐ No Radiation ? ☐ Yes ☐ No

Recent night pain or fevers/ sweats	☐ Yes ☐ No	Vision change or double vision	☐ Yes ☐ No
Unintentional weight change	☐ Yes ☐ No	Shortness of breath?	☐ Yes ☐ No
New rashes / psoriasis?	☐ Yes ☐ No	Sleep problems?	☐ Yes ☐ No
Depressed mood?	☐ Yes ☐ No	Anxiety?	☐ Yes ☐ No
Joint swelling?	☐ Yes ☐ No	Nausea, vomiting, bowel or bladder changes?	☐ Yes ☐ No

History of tobacco use? ☐ Never ☐ Yes ☐ Quit ☐ Current ☐ Cigarette packs/day _____☐ Cigar ☐ Pipe ☐ Chew
Number of caffeinated drinks per day? __________ Alcohol use? ☐ Yes ☐ No if Yes, drinks per week?_____
Do you leak urine, even a small amount? ☐ Yes ☐ No Do you have to rush to use the bathroom? ☐ 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	☐	☐	☐
Stroke/TIA	☐	☐	☐	Peripheral neuropathy	☐	☐	☐
Blood clot	☐	☐	☐	HIV/AIDS	☐	☐	☐
Asthma / Respiratory	☐	☐	☐	Hepatitis	☐	☐	☐
Emphysema	☐	☐	☐	Infectious diseases	☐	☐	☐
Diabetes	☐	☐	☐	Epilepsy / seizures	☐	☐	☐
Fibromyalgia	☐	☐	☐	Lower limb edema/swelling	☐	☐	☐

Other Present or Past Medical Conditons:____

Medications- For additional room provide a list medications

Name Reason for taking Dosage
____
____
____
____
____

Hospitalization/Surgical Procedures (not described elsewhere): Additional surgeries provide a list please

Type Date
____
____
____
____
____

Client Signature ____ Date_______________

FYZICAL
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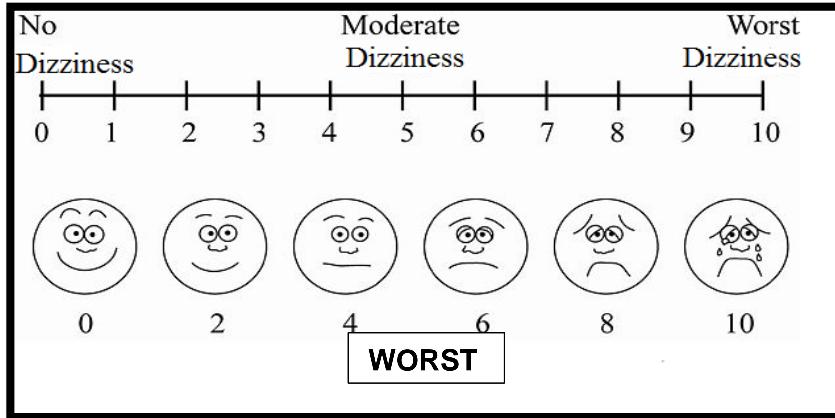
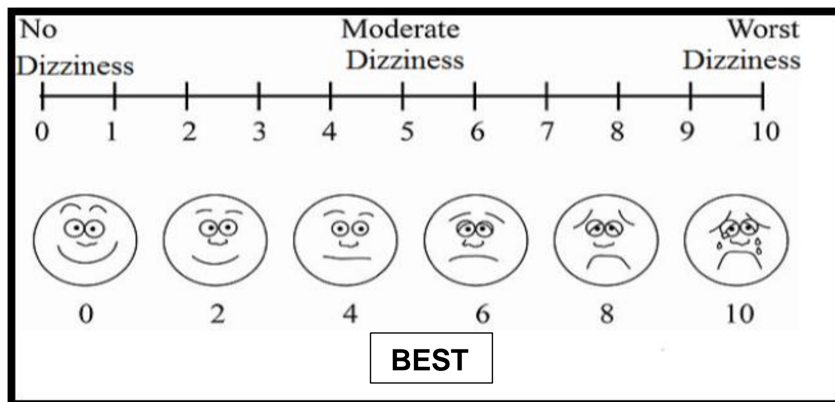
Patient Name: ______________________________ Date: ____________________

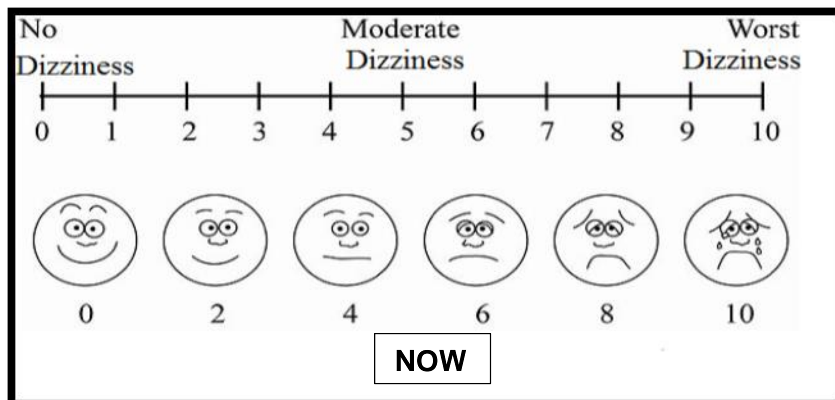
DIZZINESS SYMPTOMS SCALE

Instructions: Circle what you think your symptom is:

- **WORST**
- **BEST**
- **NOW**







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The Activities-specific Balance Confidence (ABC) Scale

Patient Name: ________________________________ DOB: ___________ Date: ____________

For <u>each</u> of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

<u>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.</u>

0% 10 20 30 40 50 60 70 80 90 100%
no confidence <---> **completely confident**

"How confident are you that you will <u>not</u> 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? ____%

---------- For Office Use Only ----------

Instructions for Scoring:
The ABC is an 11-point scale and ratings should consist of whole numbers (0-100) for each item. Total the ratings (possible range = 0 – 1600) and divide by 16 to get each subject's ABC score.

Total Score: ________________________