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?____

Insurance Information

Medicare #_____________________________ Part B effective date___________________________________

Insurance Policy #__________________________________ Group #:__________________________________

Policyholder’s Name: ____________________________ Relation to Patient:______________ DOB:__________

Insurance Address (if other than above):____

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) 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:____________________

Name: _________________________________ Date of Birth:______________________________________

Occupation_______________________________ Work status? _______________________________

Have you fallen in the last year? ☐ Yes ☐ No If yes, were you injured? ☐ Yes ☐ No describe

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 ___________________

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_______________________

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

WOMEN: Currently pregnant? ☐ Yes ☐ No Est. date of delivery_____________

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
Hypertension	☐	☐	☐	Systemic Lupus	☐	☐	☐
Chest pain Heart	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Attack Cardiac	☐	☐	☐	Osteoarthritis	☐	☐	☐
Problems Stroke/	☐	☐	☐	Osteoporosis	☐	☐	☐
TIA Blood clot	☐	☐	☐	Peripheral neuropathy	☐	☐	☐
	☐	☐	☐	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

____
____
____
____
____

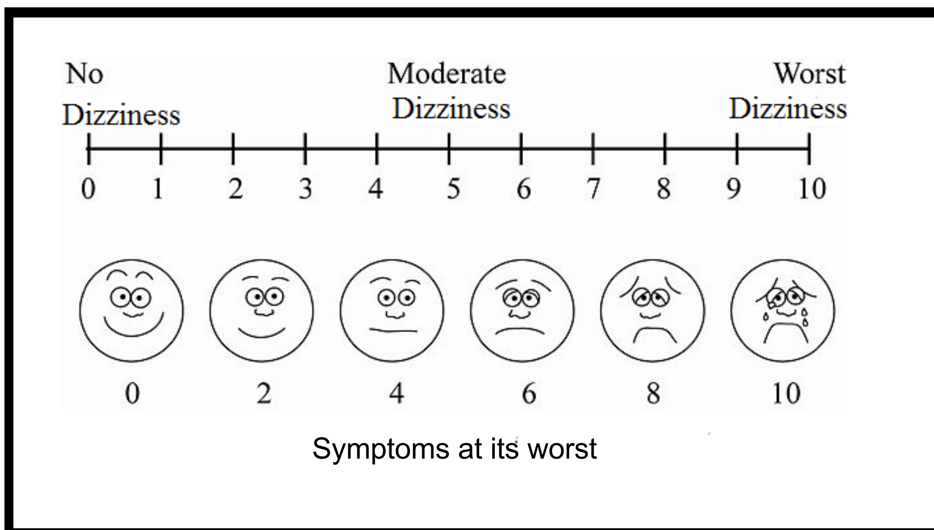
Client Signature ____ Date_________________

FYZICAL®
Therapy & Balance Centers

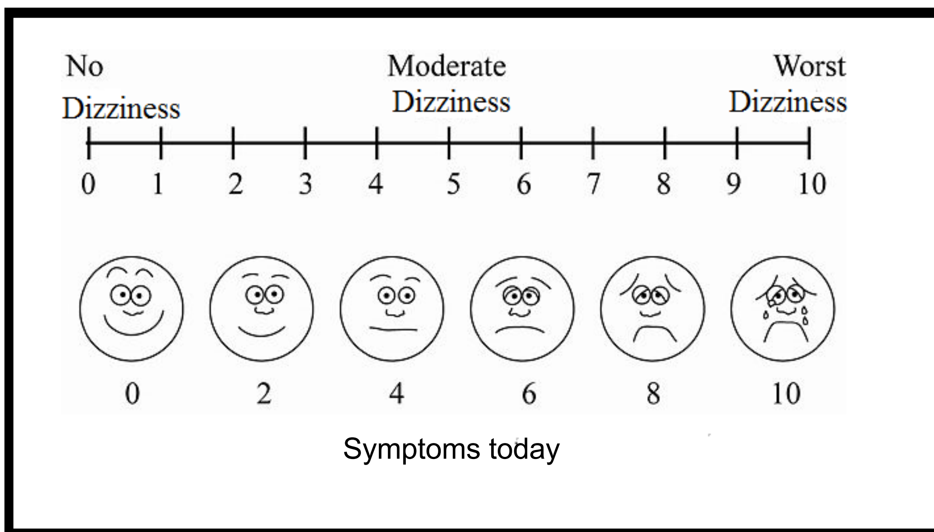
Patient Name: ______________________________ Date: ________________

Dizziness/Unsteadiness Symptoms Scale

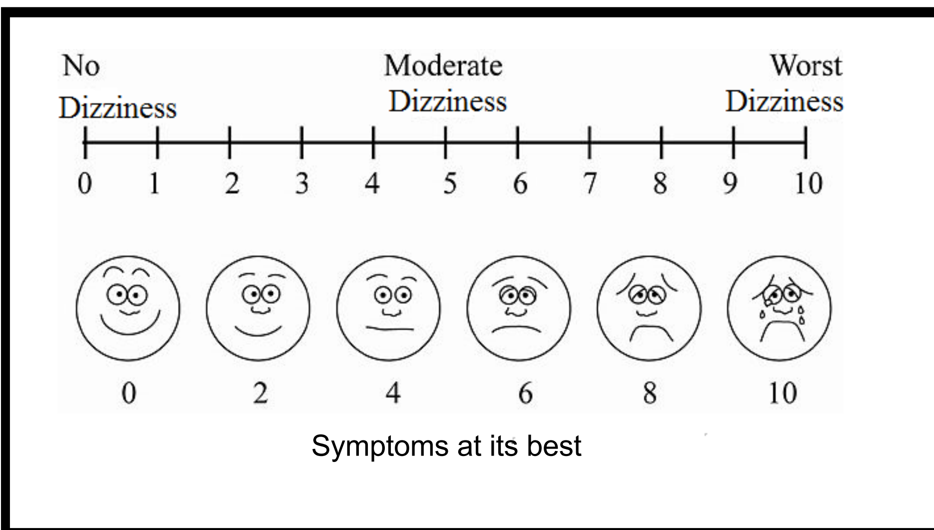
Instructions: Please rate your symptoms at its worst, at its best and today.



Symptoms at its worst



Symptoms today



Symptoms at its best

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: ____**Date:**___________________________

SECTION I

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

SECTION II - 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^1	No^2	Sometimes^3
E2.	Because of your problem, do you feel frustrated?	Yes^1	No^2	Sometimes^3
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes^1	No^2	Sometimes^3
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes^1	No^2	Sometimes^3
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes^1	No^2	Sometimes^3
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^1	No^2	Sometimes^3
F7.	Because of your problem, do you have difficulty reading?	Yes^1	No^2	Sometimes^3
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes^1	No^2	Sometimes^3
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes^1	No^2	Sometimes^3
E10.	Because of your problem, have you been embarrassed in front of others?	Yes^1	No^2	Sometimes^3
P11.	Do quick movements of your head increase your problem?	Yes^1	No^2	Sometimes^3
F12.	Because of your problem, do you avoid heights?	Yes^1	No^2	Sometimes^3
P13.	Does turning over in bed increase your problem?	Yes^1	No^2	Sometimes^3
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes^1	No^2	Sometimes^3
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes^1	No^2	Sometimes^3
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes^1	No^2	Sometimes^3
P17.	Does walking down a sidewalk increase your problem?	Yes^1	No^2	Sometimes^3
E18.	Because of your problem, is it difficult for you to concentrate?	Yes^1	No^2	Sometimes^3
F19.	Because of your problem, is it difficult for you walk around the house in the dark?	Yes^1	No^2	Sometimes^3
E20.	Because of your problem, are you afraid to stay home alone?	Yes^1	No^2	Sometimes^3
E21.	Because of your problem, do you feel handicapped?	Yes^1	No^2	Sometimes^3

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes[1]	No[2]	Sometimes[3]
E23.	Because of your problem, are you depressed?	Yes[1]	No[2]	Sometimes[3]
F24.	Does your problem interfere with your job or household responsibilities?	Yes[1]	No[2]	Sometimes[3]
P25.	Does bending over increase your problem?	Yes[1]	No[2]	Sometimes[3]

SECTION II - 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)**

Therapist Use Only			
Comorbidities:	☐Cancer ☐Diabetes ☐Heart Condition ☐High Blood Pressure ☐Multiple Treatment Areas	☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) ☐Obesity ☐Surgery for this Problem ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)	ICD Code: ________________

Dizziness Handicap Inventory © 1990, American Medical Association.

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: ________________________

- **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. We may deny you the request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **Right to Get Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured PHI.
- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or healthcare operations where an authorization was not required.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we do not disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Out-of-Pocket Payments:** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of your home. The facility will grant requests for confidential communications as alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of this Notice:** You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
- **Right to an Electronic Copy of Electronic Medical Records:** If your PHI is maintained in an electronic format you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be elective for information we already have about you as well as any information we receive in the future. The current notice will be posted and include the elective date. In addition, each time you register for treatment or healthcare services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in the office or clinic.

Phone: 240-334-2300
Fax: 240-334-2604
www.FYZICAL.com

NOTICE OF PRIVACY PRACTICES

Effective Date: September 1, 2013

HIPAA

Health Insurance Portability and Accountability Act

This notice describes how health information about you may be used and disclosed, as well as how you can get access to this information.

Please review it carefully.

If you have any questions about this notice, please contact the Office Manager.