101 Tower Rd #210
Dakota Dunes, SD 57049
(605) 217-4330

FYZICAL Therapy & Balance Centers

12499 University Ave #250
Clive, IA 50325
(515) 985-7530

Client Health Questionnaire

Name _____ Age _____ Date of Birth _____/_____/_____

Please describe your current complaint or limitation:_____

Please describe *how* and *when* your problem began:_____

List tests or other interventions for this condition that you have had: _____

Have you had other physical therapy or speech therapy this year? ☐NO ☐YES - If yes, how many sessions? _____

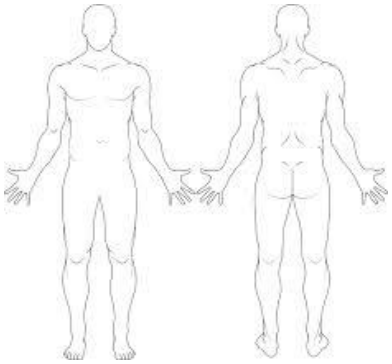
Please indicate the daily activities that you cannot perform: _____

Did you have surgery for this issue? ☐No ☐Yes Date ____/____/____ Procedure:_____

Please describe the nature of your symptoms (check **all** that apply):

Dizziness/Imbalance:	**Pelvic Health:**	**Pain Description:**
☐ Spinning/vertigo	☐ Leaking urine	☐ Sharp Pain
☐ Lightheadedness	☐ Bladder urgency	☐ Dull (Pain) Ache
☐ Imbalance	☐ Leaking bowel	☐ Throbbing
☐ Feeling "off"	☐ Pain in pelvic region	☐ Numbness
☐ Motion intolerant		☐ Shooting
☐ Migraine/Headaches	**Symptom Frequency:**	☐ Burning
☐ Ear Pressure/Pain	☐ Constant (76 – 100%)	☐ Tingling
☐ Ringing in ears	☐ Frequent (51 – 75%)	
☐ Changes in hearing	☐ Occasional (26 – 50%)	
☐ Head Injury/Concussion	☐ Intermittent (25% - or less)	

Please mark locations of pain on the picture



Level of symptoms at ***worst*** from 0 (No symptoms) to 10 (Unbearable symptoms) _____
Level of symptoms at ***best*** from 0 (No symptoms) to 10 (Unbearable symptoms) _____
Activities or positions that increase symptoms: _____
Activities or positions that decrease symptoms: _____
Occupation _____

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
☐ ☐ Incontinence
☐ ☐ Other_____
☐ ☐ Tobacco Use – 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

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**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

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Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness/imbalance. Please check "always", or "no" or "sometimes" to each question. Answer each question only as it pertains to your dizziness/imbalance problem.

	Question	Always	Sometimes	No
P1	Does looking up increase your problem?	☐	☐	☐
E2	Because of your problem, do you feel frustrated?	☐	☐	☐
F3	Because of your problem, do you restrict your travel for business or pleasure?	☐	☐	☐
P4	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
F5	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	☐	☐	☐
F7	Because of your problem, do you have difficulty reading?	☐	☐	☐
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	☐	☐	☐
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐	☐	☐
E10	Because of your problem, have you been embarrassed in front of others?	☐	☐	☐
P11	Do quick movements of your head increase your problem?	☐	☐	☐
F12	Because of your problem, do you avoid heights?	☐	☐	☐
P13	Does turning over in bed increase your problem?	☐	☐	☐
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐	☐	☐
E15	Because of your problem, are you afraid people may think that you are intoxicated?	☐	☐	☐
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	☐	☐	☐
P17	Does walking down a sidewalk increase your problem?	☐	☐	☐
E18	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	☐	☐	☐
E20	Because of your problem, are you afraid to stay home alone?	☐	☐	☐
E21	Because of your problem, do you feel handicapped?	☐	☐	☐
E22	Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
E23	Because of your problem, are you depressed?	☐	☐	☐
F24	Does your problem interfere with your job or household responsibilities?	☐	☐	☐
P25	Does bending over increase your problem?	☐	☐	☐

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The Activities-Specific Balance Confidence (ABC) Scale

Patient Name: _____ Date: _____

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 (or item) 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 (store)? _____%
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
16. hold onto the railing? _____%
17. Walk outside on icy sidewalks? _____%

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: _____

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Account # _____ **Today's Date:** _____/_____/_____

PATIENT'S NAME: _____
(First) (M.I.) (Last)
PATIENT'S DATE OF BIRTH: _____ / _____ / _____ **PATIENT'S SSN**: _____ - _____ - _____
PATIENT'S ADDRESS:_____
(Street/PO Box) (City) (State) (ZIP)
PATIENT'S HOME PHONE: (_____)_____ **CELL PHONE:** (_____)_____
EMAIL ADDRESS: _____@_____
PATIENT'S EMPLOYER: _____**PHONE:** (_____)_____

Preferred Contact Method: PHONE☐ EMAIL☐ TEXT ☐

Who is the insurance holder:_____ Relation to patient_____
Insured's: DOB _____/_____/_____ SSN:_____-_____-_____ Employer: _____

Referring Physician: _____ **Family Physician:**_____

Have you had any physical, occupational, or speech therapy this year? YES☐ NO☐

Do you wish to receive FYZICAL updates via email? YES☐ NO☐

Please Circle: Married Widowed Divorced Separated Single Common Law
Please Circle: Male Female
Please Circle: Black White Native American/Alaskan Native Hispanic/Latino Asian Other _____

Language Spoken:_____

How did you hear about us? Family Physician TV Website Billboard Social Media Internet Friend Other

If you are married, please complete the following information:
Spouse's Name: _____Date of Birth: _____/_____/_____Cell phone: (_____)_____

If patient is under 18, or under 26 on parent's insurace, complete the following information for *BOTH* parents:

Father's Name: _____
Address: _____
Phone: _____
Employer: _____
Work Phone: _____
SSN: _____ DOB: _____
Cell Phone: (_____)_____

Mother's Name: _____
Address: _____
Phone: _____
Employer: _____
Work Phone: _____
SSN: _____ DOB: _____
Cell Phone: (_____)_____

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AUTHORIZATION FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITIS

- Our office is happy to file your insurance claims for you. Please provide your insurance card and photo ID. You are required to pay your copay today upon checking out.
- If you do not have your insurance card, you will be required to prepay $200 and arrange payments for any remaining balance. Once you have supplied your insurance information, we will file your claim and refund you according to your benefits.
- If you do not have insurance coverage, you will be required to prepay $200 and must be prepared to make arrangement for any remaining balance with a post-dated check or visa/master card number upon checking out.
- My signature below gives Ear Nose and Throat Consultants/FYZICAL, and all providers within, my consent for treatment by means providers consider necessary and proper treatment of the identified patient. This treatment may require diagnostic procedures, audiology testing, laboratory testing and x-rays.
- My signature below authorizes ENT Consultants/FYZICAL to release or disclose information to the insurance companies and/or outpatient programs from my medical record pertaining to my treatment as needed to process claims.
- My signature below acknowledges that I am aware and financially responsible to ENT Consultants/FYZICAL for any and all charges not covered by this assignment.

Print Patient Name _____ **Date of Birth** _____/ _____ / _____

X_____ _____/ _____ / _____

Signature of patient / parent / or guardian **Today's Date**

HIPAA CONSENT FORM

I authorize Ear Nose and Throat Consultants and Hearing Services, PLC to release information that does contain private health information including but not limited to the following services: exams, lab and test results, prescription, purchased products, scheduling of appointments and scheduling surgery. You ***must*** check mark anyone who you want to be able to obtain information about you and your health. If you have been referred here by another physician, exam results will be sent to them automatically. I acknowledge I have been offered a copy of the Privacy Statement and I have no further questions.

Please circle: None Parents / Step Foster parents Spouse Cellular Home answering machine

Significant other (name)_____ Caregiver (name) _____

Interpreter (name) _____ Telephone number_____

In the event of an ***EMERGENCY,*** or if we are unable to reach you, please list someone ***outside of your household***

Name:_____ Telephone _____

☐By checking this box, I consent to have my FYZICAL medical records shared with my primary care provider.

X _____ _____/ _____ / _____

Signature of patient / parent/ or guardian **Today's Date**

***form valid for one year from today's date