FYZICAL®
Therapy & Balance Centers #

Patient Information Form

Patient Information Section (Please fill out *every single* line)

Patient Name _____ Age _____ Date of Birth _____ Race _____
Last First Middle

Sex: □ male □ female Social Security Number _____-_____-_____ Drivers License # / State _____

Mailing Address _____ APT # _____ City / State / Zip _____

Email: _____ Marital Status: _____

Telephone: Home # _____ Cell # _____ Work # _____ Employer _____

Language: _____ Ethnicity (please select one): □ Hispanic □ Non-Hispanic □ Refused to Respond

Primary Care Physician _____ Referring Physician/Facility _____

Emergency Contact _____ Phone # _____ Relationship _____

Preferred Pharmacy & Location _____ **Drug Allergies** _____

RESPONSIBLE PERSON INFORMATION: □ Spouse | □ Mother | □ Father | □ Guardian

Name _____ Social Security # _____ DOB _____ Employer _____

Address _____ Phone: home # _____ other # _____

PATIENT INSURANCE INFORMATION

Primary Insurance _____ Policy # _____ Group # _____

Insured Name _____ Policy Holder's DOB _____SSN _____-_____-_____ Relationship to Patient _____
Name on Insurance Card

Secondary Insurance _____ Policy # _____ Group # _____

Insured Name _____ Policy Holder's DOB _____SSN _____-_____-_____ Relationship to Patient _____
Name on Insurance Card

I hereby authorize FYZICAL Longview to furnish my health insurance company or other third party payers or their designated agents all the information which the above named entities may request concerning treatment of the patient names above.

I hereby assign to FYZICAL Longview the medical and\or surgical benefits to which I or my dependents are entitled under my health insurance plan.

I hereby authorize FYZICAL Longview to download my current medication information into my medical chart.

I understand patients canceling or rescheduling any surgery or office visit at patient's request within one business day for office visits and two business days for surgeries may be charged a cancellation and/or rescheduling fee.

I understand that regardless of insurance coverage, I am ultimately responsible for the balance of my account for any professional services rendered. I have read and completed all the information on this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature of patient or legal guardian Date

FYZICAL Longview

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND IDENTITY THEFT PROTECTION

_____ _____

PRINT Patients Name ***Patients Date of Birth***

I have been presented with a copy of the ***FYZICAL Longview.*** Notice of Privacy Policies, which details how my information may be used and declared and permitted under federal and state law. I understand the contents of the Notice and that my health information may be used for treatment, payment and health operations.

I understand that photographs, or other images may be recorded to document my care and my identity, and I consent to this. I understand that ***FYZICAL Longview*** will retain the ownership rights to these photographs or other images, but that I will be allowed to access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by. Images that identify me will be released and/or used outside the institution only upon written authorization from my legal representative or me.

With regards to communications with my family and friends, ***FYZICAL Longview***, will not discuss or release any of my health information to any of my family members or friends unless that family member is my legal representative or is named below.

Family Member/Friend Name and Relationship to patient:

_____ _____

Name ***Relationship***

_____ _____

Name ***Relationship***

_____ _____

Name ***Relationship***

_____ _____

Name ***Relationship***

If the patient is a minor child, ***FYZICAL Longview*** will disclose his/her health information only to the mother and/or father of the child.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party accepting assignment. Regulations pertaining to medical assignment of benefits apply.

_____

Signature of Patient or Legal Representative

_____

Relationship to Patient

_____

Date

( ) **Patient refused to sign acknowledgment:**

_____ _____

Signature of FYZICAL Longview Representative ***Date***

1-30-19

FYZICAL Therapy & Balance Centers

RESET FORM

PATIENT NAME: _____

MR #: _____

DATE: _____

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	1	2	3	4	5	6	7	8	9	10
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? _____

- ∫ 80 = high level of physical functioning
- 50-80 = moderate level of physical functioning
- < 50 = low level of physical functioning
- < 67 = older adults at risk for falling; predictive of future fall

ABC SCORE	**0.0%**
IMPAIRMENT	**100.0%**

Therapist Name _____ **Therapist Signature** _____

FYZICAL Therapy & Balance Centers

RESET FORM

PATIENT NAME:_____

MR #:_____

DATE:_____

DIZZINESS HANDICAP INVENTORY

	Yes	Sometimes	No	
1. Does looking up increase your problem?	○	○	○	P
2. Because of your problem, do you feel frustrated?	○	○	○	E
3. Because of your problem, do you restrict your travel for business or recreation?	○	○	○	F
4. Does walking down the aisle of a supermarket increase your problem?	○	○	○	P
5. Because of your problem, do you have difficulty getting into or out of bed?	○	○	○	F
6. Does your problem significantly restrict your participation in social events such as going out to dinner, going to the movies, dancing or to parties?	○	○	○	F
7. Because of your problem, do you have difficulty reading?	○	○	○	F
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	○	○	○	P
9. Because of your problem, are you afraid to leave your home without having someone accompany you?	○	○	○	E
10. Because of your problem, have you been embarrassed in front of others?	○	○	○	E
11. Do quick movements of your head increase your problem?	○	○	○	P
12. Because of your problem, do you avoid heights?	○	○	○	F
13. Does turning over in bed increase your problem?	○	○	○	P
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	○	○	○	F
15. Because of your problem, are you afraid people may think you are intoxicated?	○	○	○	E

PATIENT NAME:_____

MR #:_____

DATE:_____

	Yes	Sometimes	No	
16. Because of your problem, is it difficult for you to go for a walk by yourself?	○	○	○	**F**
17. Does walking down a sidewalk increase your problem?	○	○	○	**P**
18. Because of your problem, is it difficult for you to concentrate?	○	○	○	**E**
19. Because of your problem, is it difficult for you to walk around the house in the dark?	○	○	○	**F**
20. Because of your problem, are you afraid to stay home alone?	○	○	○	**E**
21. Because of your problem, do you feel handicapped?	○	○	○	**E**
22. Has your problem placed stress on your relationships with members of your family or friends?	○	○	○	**E**
23. Because of your problem, are you depressed?	○	○	○	**E**
24. Does your problem interfere with your job or household responsibilities?	○	○	○	**F**
25. Does bending over increase your problem?	○	○	○	**P**

	Total
P: Physical	**0**
E: Emotional	**0**
F: Functional	**0**
TOTAL	**0**
IMPAIRMENT	**0.0%**

16-34 Points (mild handicap)
36-52 Points (moderate handicap)
54+ Points (severe handicap)

Therapist Name _____ **Therapist Signature** _____