FYZICAL®
Therapy & Balance Centers

6717 S. 900 E., Suite 201
Midvale, UT 84047-5755
Phone: (801) 649-4690
Fax: (801) 984-4011

PATIENT INFORMATION:

Name: ____ Date: ______________

Address: ______________________ City: __________ State: _______ Zip: ________ SSN: __________

Home Phone: (______)____________ Work Phone: (_____)____________ Cell Phone: (_____)____________

Email: ______________________________ Best Way to Contact: Home Work Cell Email

Date of Birth: ____________ Age: ______ Height: ________ Weight: _________ Marital Status: ____________

Work Status: full-time part-time retired student homemaker not employed currently

Occupation: ____________________ Major Job Requirement(s): ________________________

MEDICAL INFORMATION:

Referring Individual/Physician: ________________________________ Date Last Seen: ________

Primary Care Physician: ____________________________________

How did you hear about FYZICAL? ____

Reason for P.T. Today: ____________________ Date of Onset: __________ Diagnosis: ____________

Did this Injury happen at Work? YES NO Was this a Motor Vehicle Accident?: YES NO

Surgery Date: __________ How Injury Occurred: ______________________________________

Diagnostic Test(s) Performed (X-ray, MRI, etc) and Results: ________________________________

Previous Treatment for this Injury? YES NO If so, Please List and Date:________________________

Please List any/all Medical/Health Problems: ____

Goal in Coming to P.T.: ____

MEDICATIONS: Please provide a list of medications, including: prescriptions, over-the-counter, & herbal medications, along with vitamin/mineral/dietary supplements.

Medication Name:	Dosage of Medication	Frequency	Route of administration

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SYMPTOM QUESTIONNAIRE

Please rate your pain (or symptoms) on a 0 - 10 scale. 0 being no pain or symptoms, and 10 being the worst pain or symptoms imaginable.

Pain at It's Best (0 - 10) *Pain at It's Worst (0 - 10)* *Pain Average* (0 - 10)

Please indicate if the following activities "Increase", "Decrease", or "Do Not Change" Your Symptoms:

Sitting: __________ Standing: _______ Walking: _______ Laying on Back: _______ Laying on Stomach: _______

Coughing: __________ Sneezing:__________ Voiding: ________ Up/Down Stairs: ________ Bending: _________

Other (Please List): ____

Please Check the box that Best Describe Your Pain/Symptoms (check all that apply):

Sharp Dull Achy Numbness Burning Tingling Shooting

Constant Intermittent Other (Please Describe):____

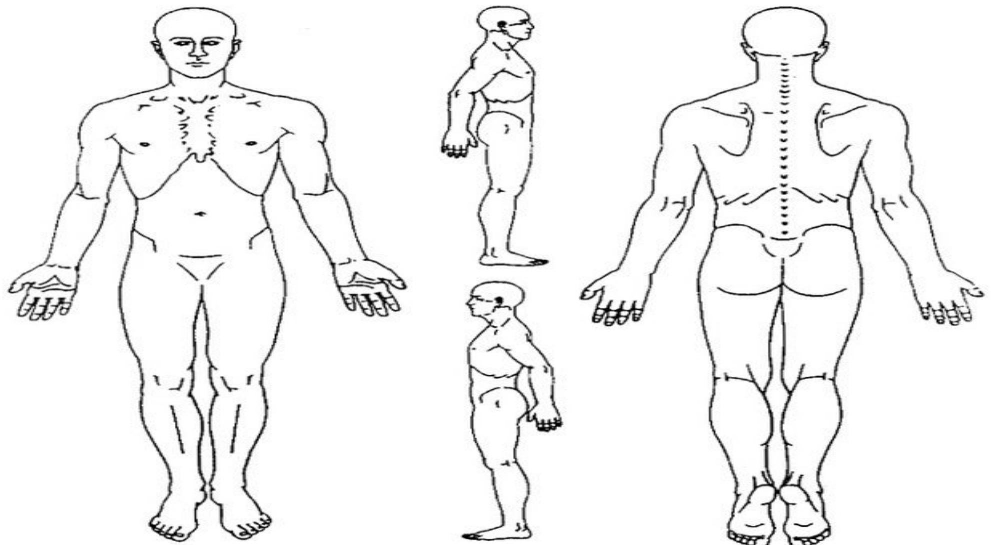
Do you have pain that wakes you up at night: YES NO If so, is it related to your position: YES NO

Any changes in bowel or bladder function recently: YES NO If so, please describe:_______________________

What percent are you limited because of this injury in your normal daily activities (0 – 100%): ______

What activities are you limited in doing because of this injury:____

Please Color/Shade the areas to identify the location(s) of your symptoms (pain, numbness, etc) on the drawing to the right. If filling this out digitally in Adobe Reader, click the "highlighter icon" to complete this chart.



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PRIVACY NOTICE

In agreeing to receive care provided by FYZICAL Therapy & Balance Centers located at 6717 South 900 East Suite 201, Midvale, Utah, 84047, I agree as follows:

I understand that in order to meet the legal requirements of the Health Insurance Portability and Accountability Act (“HIPPA”), FYZICAL requires my consent to release information from my medical and insurance records as appropriate to my medical needs, including but not limited to, chart notes, surgery reports, X-Ray and MRI reports, medical history, diagnoses, insurance coverage, payment history and demographic information, such as my social security number. This release authorizes the above types of information to be released in written, electronic and oral formats as necessary for my medical needs, insurance requirements and payments to my account.

I further understand and agree that FYZICAL providers and staff will do everything possible to keep my medical, personal and insurance information private and will release only what is necessary to provide exceptional medical care and customer service. On occasion, legal requests are made for copies of patient records. When and if this occurs, FYZICAL will abide by any court order or subpoena to provide such information. I understand that I have the right under HIPPA to examine and request copies of and changes to my medical records and to request restrictions on the uses and disclosures of my personal health information.

Name (print) ____ Date: ________________________

Signature (Patient/Parent/Guardian of patient)____
Note: You can sign in person if you are unable to sign digitally

Name of person signing on behalf of patient (print) ____

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WAIVER AND RELEASE OF LIABILITY

In agreeing to receive care provided by FYZICAL Therapy & Balance Centers located at 6717 South 900 East Suite 201, Midvale, Utah 84047, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage, as part of the treatment provided by FYZICAL and the physical therapy activities, and equipment I may use as a part of that treatment have inherent risks and dangers and are potentially dangerous activities; (b) my participation in such activities and/or use of such equipment may result in serious bodily injury. By my participation in these activities, I hereby accept the responsibility and assume all risks and dangers for any harm, injury or damage whether caused in whole or in part by the negligence or the conduct of the representatives or employees of FYZICAL, or by any other person.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend and indemnify FYZICAL Therapy & Balance Centers and its representatives, employees and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in physical therapy activities, whether the result of negligence or any cause. I voluntarily and knowingly acknowledge, accept and assume these risks.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE TO COMPLETELY RELEASE AND RELIEVE FYZICAL FROM ANY LIABILITY FOR INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name (print): ____ Date: __________________

Signature (Patient/Parent/Guardian of Minor): ____
Note: You can sign in person if you are unable to sign digitally

Name of Person Signing on Behalf of Patient (print): ____

Consent to Photograph, Video, or Record Form

Requesting Organizations: FYZICAL Therapy & Balance Centers
Address: 6717 South 900 East Suite 201 Midvale, Utah 84047
Phone: 801-649-4690

I, ____________________________, a current patient at FYZICAL Therapy & Balance Centers hereby authorize the about organization to:

Check all that apply

- ❏ Photograph me
- ❏ Video me
- ❏ Record my voice

I also grant FYZICAL Therapy & Balance Centers the right to edit, use and reuse said products to non-profit purposes including in print, on the internet, and all other forms of media. I also hereby release FYZICAL Therapy & Balance Centers and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Signature of Parent/Guardian (under 18) ____

Address of Parent/Guardian ____

OR *Note: You can sign in person if you are unable to sign digitally*

Signature of Patient (over 18) ____

Address of Patient ____

Date: ___________________________