FYZICAL
Therapy & Balance Centers

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**

Consent For Treatment

I hereby give my consent for medical treatment of my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible to inform the office of any changes that occur with regard to my insurance policy. If I choose to file a claim through my insurance, I authorize release of payment directly to Fyzical Therapy and Balance Centers regardless of whether benefits are deemed to be in-network or out-of-network. Should I default on my financial responsibility and monetary collection is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

Patient/Parent/Guardian Name (Please Print): _____

Receipt of Policies

I acknowledge that I have received the packet of patient policies which includes the following: HIPAA Notice of Privacy Practices, Attendance Policy, Financial Policy, and Financial Responsibilities. I understand that I may ask questions about these policies at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

Contact Information

1) Please indicate any family members we may speak with regarding your care including but not limited to diagnosis, treatment plan, or prognosis.

_____ _____

_____ _____

2) May we leave a message on your answering machine/cell phone? Yes No

3) How would you like to receive appointment reminders? Phone Email

NOTE: By choosing one of the above options, I authorize Fyzical Therapy and Balance Centers or entities acting on behalf of Fyzical Therapy and Balance Centers (e.g. debt collection agency) to deliver messages to me using an automated dialing system and/or artificial pre-recorded voice in accordance with the FCC's Telephone Consumer Protection Act. I understand that by choosing "No" I have opted not to receive messages using an automated dialing system or pre-recorded voice.

Child/Adolescent Protection Policy (For patients under 18 years of age)

It is the policy of Fyzical Therapy and Balance Centers to release minors only to the care of the following individuals after completion of their physical therapy visit.

_____ _____

_____ _____

Patient/Parent/Guardian Signature: _____ Date: _____

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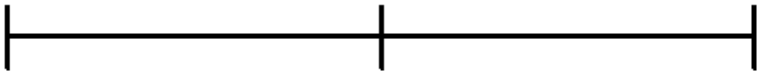
Patient Name: _____ Date: _____

Functional Assessment (OPTIMAL)

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about <u>*all*</u> of the activities you would like to do, please mark an "X" at the point on the line that best describes your <u>*overall*</u> level of difficulty with these activities today.



I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1.* <u>*12*</u> *2.* <u>*8*</u> *3.* <u>*13*</u>)

1.____ 2.____ 3.____

Present Total Score = _____ Previous Total Score = _____

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther*. 2005;85:515-530.

FYZICAL Therapy & Balance Centers

Confidential Medical History

Name: _____ **Date of Birth** _____/_____/_____ **SS#:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Cell:** _____ **E-mail:** _____

Emergency Contact & Phone #: _____

Marital Status (Circle): M S D W **Are you presently working?** Y___ N___ **Occupation:** _____

Employer: _____ **Employer Phone:** _____

Insurance Company: _____ **ID#:** _____

Name of Card Holder: _____ **Date of Birth** _____/_____/_____ **SS#:** _____

Card Holder's Employer: _____

Have you received any of the following services during your current insurance plan year?

Occupational Therapy	**Y___ N___**	**Massage Therapy**	**Y___ N___**
Physical Therapy	**Y___ N___**	**Chiropractic Services**	**Y___ N___**
Speech Therapy	**Y___ N___**	**Home Health Services**	**Y___ N___**

Do you have any of the following medical conditions?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	**Osteoporosis**	_____	_____
Shortness of Breath or Chest Pain	_____	_____	**Arthritis or Swollen Joints**	_____	_____
Coronary Heart Disease	_____	_____	**Bowel or Bladder Problems**	_____	_____
Pacemaker	_____	_____	**Sleeping Difficulties**	_____	_____
High Blood Pressure	_____	_____	**Emotional or Psychological Problems**	_____	_____
Heart Attack or Surgery	_____	_____	**Severe or Frequent Headaches**	_____	_____
Stroke or TIA	_____	_____	**Vision or Hearing Difficulties**	_____	_____
Blood Clot or Emboli	_____	_____	**Dizziness or Faintness**	_____	_____
Epilepsy or Seizures	_____	_____	**Pregnancy**	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	**Gout**	_____	_____
Anemia	_____	_____			
Infectious Diseases	_____	_____	**Other Medical Conditions:** _____		
Diabetes	_____	_____	_____		

Referring Physician: _____ **Referral Date:** _____

Chief Complaint: _____ **Date of Injury:** _____

Current Symptoms: **Pain** **Numbness** **Stiffness** **Weakness** **Other:** _____

List all medications you are currently taking: □ **None** _____

_____

List any known allergies: □ **None** _____

List any previous surgeries: □ **None** _____

Have you had any diagnostic imaging for this injury? □ **None** **MRI** **XRAYS** **CT SCAN** **Other:** _____

Do you smoke? **Y___ N___** **How much/often?** _____

Do you consume alcohol? **Y___ N___** **How much/often?** _____

Do you exercise regularly? **Y___ N___** **How much/often?** _____