FYZICAL
Dizziness & Fall Prevention Centers

CLIENT INFORMATION

Last Name:_____FirstName:_____MiddleInitial:_____
Address:_____Apt:_____
City:_____State:_____Zip:_____
Date of Birth:_____Sex:_____Social Security #:_____
Home Phone #:_____Work #:_____ Cell #:_____
Emergency Contact:_____Phone#:_____Relationship:_____
Primary Doctor:_____ Referring Doctor:_____
Are you currently receiving Home Health Care: YES / NO
If yes, Company:_____
Have you had any physical, occupational, or speech therapy this year? YES / NO.
How did you hear about FYZICAL? _____

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 the procedures performed during visits to FYZICAL Dizziness and Fall Prevention Center. 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 for services rendered. FYZICAL may appeal for unpaid or delayed claims; however, I understand and agree that this does not relieve me of my responsibility for all charges incurred.

Medicare Annual Cap and Home Health Episodes:
Medicare places an annual limit ($1980 for 2017) on the combine total amount of physical therapy and speech therapy that can be received. Previous therapy in this calendar year counts toward that total. An exception to this cap may be made if both my physical therapist and referring doctor agree that I can continue to benefit from skilled care. I understand that if Medicare indicates I am in a home health episode during the course of my treatment, Medicare will not cover the cost of outpatient physical therapy and the claims will be my responsibility.

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.

Condition Precedent, Referrals, Pre-Certifications/Pre-Authorizations:
It is the patient's responsibility to obtain any necessary referrals, precertification, and authorizations. I understand that failure to do so will leave me financially responsible for the charges and that obtaining these referrals/pre-certifications/authorizations does not relieve me of financial liability.

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 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 patients rights and responsibilities handout.

Client/Guardian/Legal Representative Signature: _____
Printed Name: _____ Date:_____

Dizziness Handicap Inventory

FYZICAL Therapy & Balance Centers

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

	Questions	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?	☐	☐	☐

Scoring for Dizziness Handicap Inventory

Eval	Total Functional	Total Emotional	Total Physical	TOTAL SCORE
Reassess #1				
Reassess #2				
Reassess #3				
Reassess #4				

Always = 4

Sometimes = 2

No = 0

P = physical

E = emotional

F = functional

Subscales

Notes:

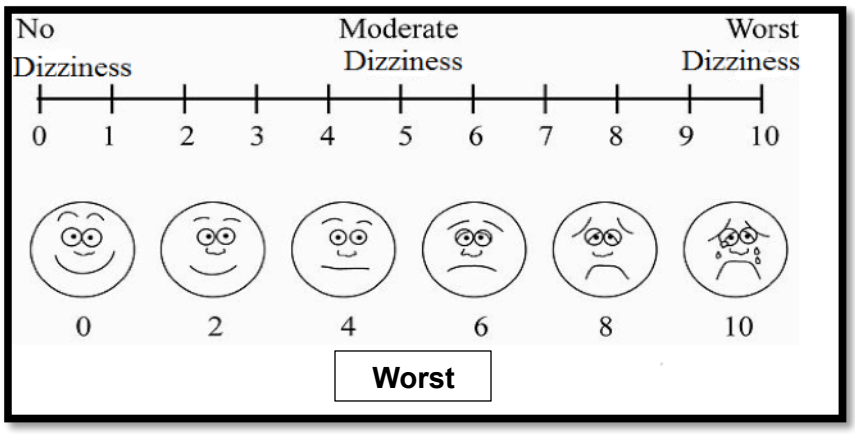
1. **Subjective measure of the patient's perception of handicap due to the dizziness**
2. **Top score is 100 (maximum perceived disability)**
3. **Bottom score is 0 (no perceived disability)**
4. **The following 5 items can be useful in predicting BPPV**
   - **Does looking up increase your problem?**
   - **Because of your problem, do you have difficulty getting into or out of bed?**
   - **Do quick movements of your head increase your problem?**
   - **Does bending over increase your problem?**
5. **Can use subscale scores to track change as well**

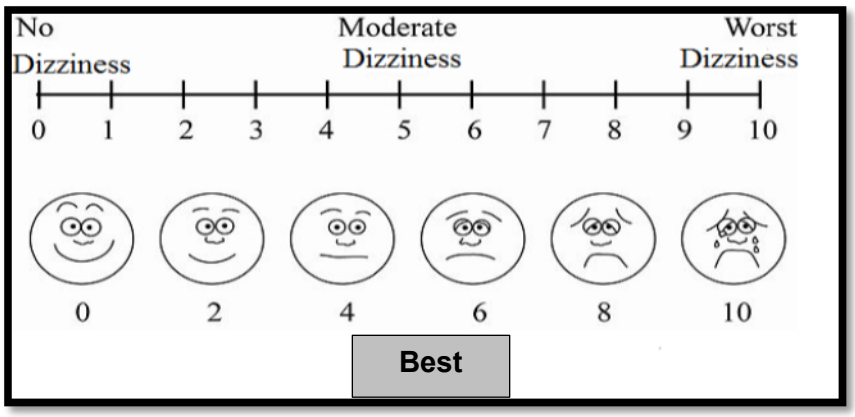
Patient Nombre: _____ Fecha: _____

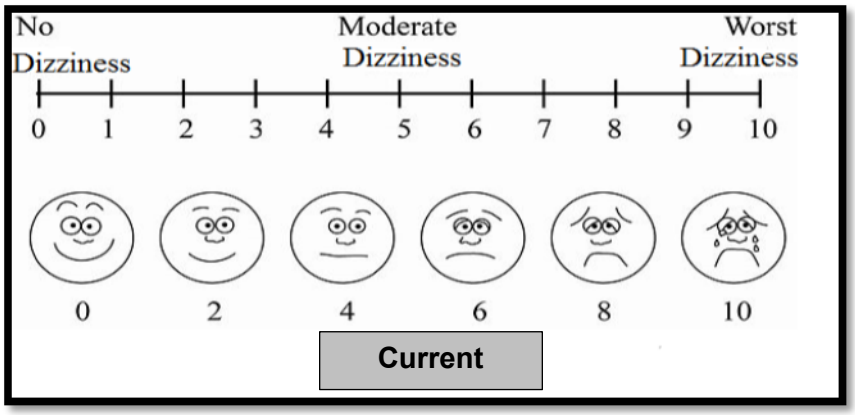
Dizziness Symptom Scale

Insturctions: Circle what you think your symptoms are at

- **Worst**
- **Best**
- **Current**







FYZICAL Therapy & Balance Centers

PRE-EXAM HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____/_____/_____

What is your Current Complaint or Limitation? _____

When did your condition start? _____

What daily activities are you having difficulty with due to this condition? _____

_____

Did you have surgery? (circle one) YES / NO Date: _____ Procedure:_____

Occupation: _____

Please check all of your symptoms:

___ Vertigo	___ Sharp Pain	___ Constant
___ Lightheadedness	___ Dull Pain (Ache)	___ Frequent
___ Imbalance	___ Throbbing	___ Occasional
___ Feeling “off”	___ Numbness	___ Intermittent
___ Ear Pressure/Pain	___ Shooting	
___ Motion Intolerant	___ Burning	
___ Migraine/Headaches	___ Tingling	
___ Head Injury/Concussion		

Since your symptoms began have they (check one):

___ Decreased ___ Increased ___ Not Changed

Please circle any conditions you have/had:		Pacemaker	Diabetes	Seizures
High/low Blood Pressure	Heart Condition	Stroke	Asthma	HIV/AIDS
Osteoporosis	Diabetes	Seizures	Pregnancy	Tobacco use
Drug/Alcohol dependence	Hepatitis	Cancer- Location _____		Date: _____

Allergies: _____

Patient Name: _____ Date: _____

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants: For each of the following activities, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100% If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports.

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 from the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tip toes 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 of 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? _____%

*Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1):M28-34.

Total ABC Score: _____

Scoring: _____ / 16 = _____% of self confidence
Total ABC Score

MEDICARE PATIENTS ONLY
100% - _____% Function = _____% Impairment

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____