Client Demographic Information

Today's Date:_____

FYZICAL Therapy & Balance Centers

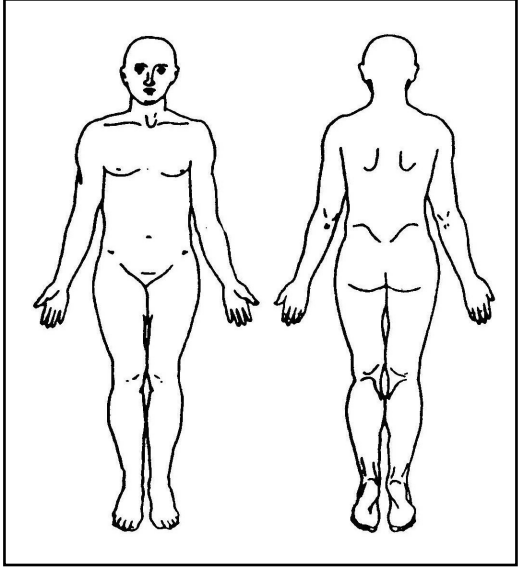
Name: _____ Date of Birth:_____
Phone Number: _____ Emergency Contact(Name and Phone): _____
Email: _____ _____
How did you hear about us? ☐ Doctor ☐ Friend ☐ Internet ☐ Other_____
How would you like to receive reminders about your appointment? ☐ Text ☐ Phone call ☐ Email
Occupation_____ Work status? _____
Dominant hand ☐ Right ☐ Left ☐ Ambidextrous

Have you fallen in the last year? ☐ Yes ☐ No If yes, were you injured? ☐ Yes ☐ No describe _____
How much physical activity or exercise per week? ☐ 30+ minutes 5+days/week ☐ 30+min 3-5 days/wk
☐ 30+min 1-3 days/wk ☐ less than 30 minutes 1-3 days/wk ☐ not regularly exercising ☐ Other _____
Are you interested in learning about how a medically based fitness program can safely optimize your health?
☐ Yes ☐ No
What daily activities are you having difficulty performing? _____
What are your goals for physical therapy? _____
Do you have difficulty hearing? ☐ Yes ☐ No Do you have hearing aids? ☐ Yes ☐ No

Symptom Questionnaire

What problem or issue brings you here? _____
How and when did it start? _____
Did you have surgery? ☐ Yes ☐ No Procedure: _____ Date of surgery? _____
What tests have you had? ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Bone scan ☐ Other _____
What treatments have you had? ☐ Physical Therapy ☐ Massage ☐ Chiropractic ☐ Other _____
_____

Mark or shade the locations of your pain on the picture below



Please describe your pain or chief symptoms: (check all that apply)

☐ Vertigo, room spinning
☐ Light headedness
☐ Imbalance
☐ Ear pressure/pain
☐ Motion intolerance
☐ Headaches/migraine
☐ Head injury/concussion
☐ Tingling
☐ Burning
☐ Shooting
☐ Throbbing
☐ Dull pain / ache
☐ Sharp pain

Please describe the intensity and pattern of symptoms:

Symptoms are...
☐ Getting better
☐ Not changing
☐ Getting worse

Symptoms are worse…
☐ Morning
☐ Afternoon
☐ Night
☐ Constant

Activities/positions that increase symptoms_____
Activities/positions that decrease symptoms_____

Place marks on lines to indicate your level of pain/ symptoms
0= no pain/symptoms 5= symptoms cause you to stop activities 10= must go to hospital

Please rate your **CURRENT** level of pain or symptoms on the line below

_____
0 1 2 3 4 5 6 7 8 9 10

Please rate your **BEST** level of pain or symptoms on the line below

_____
0 1 2 3 4 5 6 7 8 9 10

Please rate your **WORST** level of pain or symptoms on the line below

_____
0 1 2 3 4 5 6 7 8 9 10

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Do you have a pacemaker? ☐ Yes ☐ No Do you have high blood pressure? ☐ Yes ☐ No What is usual BP? _____
Do you have any joint replacements or metal implants? ☐ Yes ☐ No Please list types and dates: _____

Do you have a history of cancer or tumors? ☐ Yes ☐ No Please describe type and date: _____
_____ Chemotherapy ? ☐ Yes ☐ No Radiation ? ☐ Yes ☐ No

Recent night pain or fevers/ sweats	☐ Yes ☐ No	Vision change or double vision	☐ Yes ☐ No
Unintentional weight change	☐ Yes ☐ No	Shortness of breath?	☐ Yes ☐ No
New rashes / psoriasis?	☐ Yes ☐ No	Sleep problems?	☐ Yes ☐ No
Depressed mood?	☐ Yes ☐ No	Anxiety?	☐ Yes ☐ No
Joint swelling?	☐ Yes ☐ No	Nausea, vomiting, bowel or bladder changes?	☐ Yes ☐ No

History of tobacco use? ☐ Never ☐ Yes ☐ Quit ☐ Current ☐ Cigarette packs/day _____☐ Cigar ☐ Pipe ☐ Chew
Number of caffeinated drinks per day? _____ Alcohol use? ☐ Yes ☐ No if Yes, drinks per week?_____
Do you leak urine, even a small amount? ☐ Yes ☐ No Do you have to rush to use the bathroom? ☐ Yes ☐ No

WOMEN: Currently pregnant? ☐ Yes ☐ No Est. date of delivery_____ Number of pregnancies? _____
Number of vaginal deliveries? _____ Number of C-sections? _____Date of last menstrual period? _____
Hysterectomy? ☐ Yes ☐ No Date_____ Pelvic organ prolapse? ☐ Yes ☐ No Type _____

Medical History and Family History. If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. If you have a family history of a condition, check it in the FAMILY column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

CONDITION	PAST	PRESENT	FAMILY	CONDITION	PAST	PRESENT	FAMILY
Angina	☐	☐	☐	Systemic Lupus	☐	☐	☐
Chest pain	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Heart Attack	☐	☐	☐	Osteoarthritis	☐	☐	☐
Cardiac Problems	☐	☐	☐	Osteoporosis	☐	☐	☐
Stroke/TIA	☐	☐	☐	Peripheral neuropathy	☐	☐	☐
Blood clot	☐	☐	☐	HIV/AIDS	☐	☐	☐
Asthma / Respiratory	☐	☐	☐	Hepatitis	☐	☐	☐
Emphysema	☐	☐	☐	Infectious diseases	☐	☐	☐
Diabetes	☐	☐	☐	Epilepsy / seizures	☐	☐	☐
Fibromyalgia	☐	☐	☐	Lower limb edema/swelling	☐	☐	☐

Other Present or Past Medical Conditons:_____

Medications- For additional room provide a list medications
Name Reason for taking Dosage

_____
_____
_____
_____
_____

Hospitalization/Surgical Procedures (not described elsewhere): Additional surgeries provide a list please
Type Date

_____
_____
_____
_____
_____

Client Signature _____ Date_____

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Patient Acknowledgement Form

Please Read and Initial:

_____ I consent to **evaluation and treatment** by FYZICAL Therapy and Balance Centers and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ The filling of insurance claims is a courtesy that we extend to our patients. **You will be responsible for any charges not reimbursed or contractually adjusted by your insurance company.** Should your claims not process as you expected or should you have any questions regarding your insurance plan benefits, Please contact your insurance company directly.

_____ I authorize the **release of information** acquired in the course of my treatment including by not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, other third party payers and/or the following (i.e spouse, family member, friend: _____)

_____ I authorize **phone, e-mail, and/or text messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ I have received and/or been offered a copy of this facility's **Notice of information/ Privacy Practices** has been provided to me.

_____ Medicare beneficiaries have an annual cap for combine therapy services including Physical, Occupational, and Speech Therapies.

_____ A $35.00 charge will be charged for any returned checks.

_____ Should a patient account become 60 days past due the account will be placed with a collection agency and a $35.00 collection fee will be charged.

_____ I hereby **assign** to FYZICAL Therapy and Balance Centers all payment for medical services rendered to myself or my dependants. **I understand I am responsible for any amount not covered by my insurance.**

_____ **I understand I will be charged a fee of $25.00 for cancelled or missed appointments without 24 hour notice. Payment must be rendered prior to next scheduled visit.**

_____ _____
Patient Signature Today's Date

_____ _____
Patient Legal Representative Today's Date

Client Name: _____

Date: _____

Case #: _____

FYZICAL Therapy & Balance Centers

Client Needs Screen (CNS)

1. Have you had a fall in the past year?	☐ Yes ☐ No
2. Do you have a fear of falling?	☐ Yes ☐ No
3. Would you like your balance to be assessed?	☐ Yes ☐ No
4. Do you experience dizziness or imbalance?	☐ Yes ☐ No
5. Do you lose your balance when stepping up/down curbs or stairs/steps?	☐ Yes ☐ No
6. Do you have a difficult time walking in the dark?	☐ Yes ☐ No
7. Do you have difficulty hearing?	☐ Yes ☐ No

8. Do you have osteoporosis, osteoarthritis and/or joint pain?	☐ Yes ☐ No
9. Do you take bone and/or joint supplements?	☐ Yes ☐ No
10. Do you experience muscle aches, pains and/or muscle cramping?	☐ Yes ☐ No
11. Do you use cold, heat or compression therapy at home?	☐ Yes ☐ No
12. Are you interested in learning how compression clothing with ice could help your condition?	☐ Yes ☐ No
13. Are you interested in learning how home heat and/or cold therapy could help your condition?	☐ Yes ☐ No

14. Do you have foot and/or ankle pain/discomfort?	☐ Yes ☐ No
15. Do you currently wear shoe inserts?	☐ Yes ☐ No
16. Are you interested in learning about how a shoe insert could help your condition?	☐ Yes ☐ No
17. Do you have pain and/or physical challenges other than what you are being seen for today?	☐ Yes ☐ No
18. Would you like to get more information about your whole body health?	☐ Yes ☐ No
19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	☐ Yes ☐ No

Patient Name: _____
Today's Date: _____

FYZICAL Therapy & Balance Centers

Medicare Questionnaire

Medicare Beneficiaries Over age 65

1. Are you currently working full or part-time? Yes _____ No _____
2. Are you married? Yes _____ No _____
   a. If so, does your spouse work full or part-time? Yes _____ No _____
   b. If yes, how many employees does your employer or spouse's employer have? Yes _____ No _____
3. Are you covered under an employer group health plan based on your current employment, or current employment of a spouse? Yes _____ No _____
4. Are you entitled to Black Lung Medical Benefits? (i.e. As a result of working in a coal mine.) Yes _____ No _____
5. Was this service for the treatment of a work-related injury? Yes _____ No _____
6. Was this service for the treatment of an illness or injury which resulted from an auto/other accident? Yes _____ No _____
7. Are the service to be paid by a government program such as a research grant? Yes _____ No _____
8. Has the department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? Yes _____ No _____

Screening for Future Fall Risk

Medicare defines a fall as a sudden, unintentional change in position causing you to land at a lower level, on an object, the floor or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure or overwhelming external force.

1. Have you had two or more falls in the past year? Yes _____ No _____
2. Have you had any fall resulting in injury in the past year? Yes _____ No _____

Home Health

Have you received **ANY** Home Health Care in the last 60 days, this includes any provider physically coming to your house to perform any service/s? **Circle one.**

YES **NO**

IF YES, provide last date of service: _____

Name of Agency: _____

Telephone Number: _____

_____ _____

Patient Signature FYZICAL Staff Signature

For office use only

_____ Called Home Health Agency to confirm Discharge Date.

_____ Spoke to _____ at _____

_____ Patient Discharged on _____

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INFORMED CONSENT

I understand that COVID-19 is highly contagious and still present in the community where I am seeking therapy. I understand that COVID-19 is passed through close contact with others and that people without symptoms may be infectious. I understand that this business has taken every precaution to ensure my health and safety but that risk of infection is still possible.

Signature_____ Date_____

HIGH RISK ASSESSMENT

I understand that the heath conditions listed on page 2 of this document place me or my dependent at higher risk for serious illness from COVID-19 infection. If I have one of these conditions I or my dependent should forgo therapy while COVID-19 is still present in my community, or obtain my physician's consent to receive therapy. Should I or my dependent decide to proceed with therapy I assume all risk related to illness from COVID-19 infection.

Signature_____ Date_____

DEPARTMENT OF HEALTH AND EXPOSURE TO COVID-19

I understand that in the event that a client, therapist, or staff member of this facility tests positive for COVID-19 within a time period that places me at risk of exposure, my name and contact information will be shared with the State Department of Health for their follow-up. In the event that I develop symptoms of illness within two weeks of my appointment, I will contact this facility immediately.

Signature_____ Date_____

EXPOSURE REPORTING

I understand that if I come into contact with anyone who is positive for a COVID-19, of have been paced in mandatory or precautionary quarantine I will contact the office immediately.

Signature_____ Date_____

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1. In the past 14 days have you had contact with anyone that you know has been diagnosed with COVID-19?

   Yes_____ No_____

2. Have you had a positive-COVID test for active virus in the past 14 days?

   Yes_____ No_____

3. Do you have of these symptoms that you cannot attribute to another condition?

   - Fever or chills
   - Cough
   - Shortness of breath or difficulty breathing
   - Fatigue
   - Muscle or body aches
   - Headache
   - Recent onset of loss of taste or smell
   - Sore throat
   - Congestion
   - Nausea or vomiting
   - Diarrhea

   Yes_____ No_____

4. Have you traveled to any states that have a mandatory quarantine per the New York State mandate within the last 14 days?

   Yes_____ No_____

Signature: _____ Date: _____