THERAPY AND BALANCE CENTERS OF SEQUIM
522 N 5TH AVE, SEQUIM, WA 98382 Phone: 360-683-0632 Fax: 360-681-5483

Patient Information

Last Name: ______________________ First Name: ____________________ Middle Initial: ________

Email: ______________________________ Sex: __________ Date of Birth: ________________

Address: ____________________________ City: __________ State: ________ Zip: ____________

Home Phone: ______________ Work Phone: ________________ Cell/Alternate: ______________

Marital Status: __Single __Married __Divorced __Widowed Social Security #: ________________

Emergency Contact: __________________ Phone: ________________ Relationship: ____________

Primary Care Physician/Family Doctor(s): ________________________ Phone: ________________

Are you currently under the care of a Home Health Agency? __No __Yes, Name of Agency: ______________

How did you hear about FYZICAL? __Online __Phone Book __Newspaper __Friend __Other: ______________

If Patient is a minor

Responsible party for bill if other than patient: ______________________ Relationship: ____________

Responsible party's address (if other than above): ____________________________________

Date of Birth: ________________ Social Security # ____________________________________

Consent for Treatment:
I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as is deemed necessary or advisable by the physical therapist. If patient is under 18 years of age, see below. **INITIALS:** ________

Parent, Power of Attorney, Durable Power of Attorney or Guardian Signature for Consent to Treat:

____ (circle one): **Parent DPOA POA Guardian**

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 and Guarantee of Payment:
I hereby authorize payment to be made directly to FYZICAL. 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. Insurance coverage is between the patient, employer and/or insurance company.
It is the patient's responsibility to determine physical therapy benefits, authorizations, referrals, co-pays, etc.
It is also the patient's responsibility to follow up with the insurance company on all unpaid visits. If a payment plan is necessary, please contact our Billing Specialist at (360) 683-0632 right away. Accounts past 90 days past due may incur interest up to 12% of the unpaid balance. Any balances over 120 days past due without a payment arrangement will be subject to collection proceedings.

No-Show/Cancellations:
Cancellations or changes should be made 24 hours in advance other than emergency situations.
You may be charged a $25.00 No-Show fee if we are not given 24 hrs. notice.

Protecting your Personal Health Information:
FYZICAL Therapy and Balance will only use and disclose information we collect from you as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. Your Personal Health Information will never be otherwise given to anyone without your written consent.

I authorize disclosure of my information: (please initial next to each one you authorize)

____ Any member of my immediate family ____Spouse only ____Other__________________________

____ I authorize detailed information to be left on my voice mail or answering machine.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature:______________________________ Date:________________

FYZICAL®

Client Health Questionnaire

Name ________________________________ DOB: ___________ Date ______________

Please describe your Current Complaint or Limitation: ______________________________

Primary Insurance:____________________ Policy #____________________ Group#______________

Secondary Insurance:____________________ Policy #____________________ Group#______________

Policy Holder Name:____________________ Relationship to patient:______________ INS and ID on file: YES NO

Please describe how your problem began: ______________________________

List tests or other interventions for this condition that you have had: ______________________________

____

Please indicate the daily activities that you cannot perform: ______________________________

Please inform us of any environmental or living conditions that may have difficulties with:______________________

Present: Weight ______ Height _____ft. _____in.

Do you have a Pace Maker: YES NO

Have you fallen in the last year? ☐ NO ☐ YES - If yes, how many?______

Did you sustain any injuries from a fall in the last year? ☐ NO ☐ YES

If yes, what injury?______________________________

Appointment Reminders: Text Call

Please describe the nature of your symptoms (check **all** that apply):

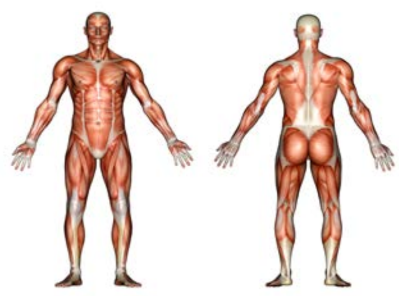
- ☐ Fatigue
- ☐ Pregnant
- ☐ Fever/Night Sweats
- ☐ Shortness of breath
- ☐ Ear Pressure/Pain
- ☐ Head Injury/Concussion
- ☐ Persistent pain at night
- ☐ Swelling/Lymphedema
- ☐ Problems with coordination
- ☐ Sudden weakness or fainting
- ☐ Problems with swallowing or speech
- ☐ Unexplained weight loss or loss of appetite
- ☐ Pulsing pain anywhere in your body
- ☐ Constant pain anywhere in your body
- ☐ Swelling or redness in any joints
- ☐ Dizziness/Balance problems/falling

0 1 2 3 4 5 6 7 8 9 10
Pain level at the worst

0 1 2 3 4 5 6 7 8 9 10
Pain level currently

0 1 2 3 4 5 6 7 8 9 10
Pain level at the best

Please mark on the picture locations of pain:



Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Your symptoms are worse in: ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day

Activities or positions that increase symptoms: ______________________________

Activities or positions that decrease symptoms: ______________________________

Occupation ______________________ Has your work status changed because of this condition ☐YES ☐NO

Please check any of the following that apply to you:

- ☐ Peripheral Vascular Disease (or claudication)
- ☐ Headaches
- ☐ Diabetes Type I or II
- ☐ Gastrointestinal Disease **(ulcer/hernia/reflux/bowel/liver/gall-bladder)**
- ☐ Visual Impairment **(cataracts, glaucoma, macular degeneration)**
- ☐ Hearing Impairment **(very hard of hearing, even with hearing aids)**
- ☐ Back pain **(neck pain, low back pain, degenerative disc disease, spinal stenosis)**
- ☐ Kidney, Bladder, Prostate, Urination Problems
- ☐ Previous Accidents_______
- ☐ Allergies

- ☐ Incontinence
- ☐ Anxiety/Panic Disorders
- ☐ Hepatitis, Tuberculosis, HIV, AIDS (or other blood-borne condition)
- ☐ Prior Surgery ____________
- ☐ Prosthesis/Implants ________
- ☐ Sleep Dysfunction
- ☐ Cancer ________________

Medication: (Name/Dosage/Frequency/Route Administered)

____

____

____

**If you need additional room for medications please bring a separate document on your next visit.

Hospitalization/Surgical Procedures (list if not described elsewhere):

____

____

____

1. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking **prior to the onset** of your condition?
   ☐At least 3 times a week ☐Once or twice a week ☐Seldom or Never
2. Have you ever received treatment for this condition before? YES NO
3. How many days ago did your condition begin?
   ☐0 - 7 days ☐ 8 - 14 days ☐ 15 - 21 days ☐ 22 - 90 days ☐ 91 days - 6 months ☐ Over 6 months

In the past month, have you:

Often been bothered by feeling down, depressed, or hopeless? YES NO

Often been bothered by little interest or pleasure in doing things? YES NO

Have you ever been diagnosed with depression or bipolar disorder? YES NO

FYZICAL THERAPY AND BALANCE CENTERS OF SEQUIM

OPTIMAL INSTRUMENT DIFFICULTY - BASELINE

NAME:______________________
DATE:______________________

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. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

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. 13 2. 8 3. 14)*

1.____ 2.____ 3.____

24. From the above list of three activities, choose the primary activity 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* without any difficulty, you would choose: Primary goal. *13*)

Primary goal. ____

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