FYZICAL®

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: (<u>please initial next to each one you authorize</u>)

____ 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® Osteo - 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
Have you had a bone density test in the last 2 years? YES NO Copy of Bone Density Test on file: YES NO
Appointment Reminders: ☐ TEXT ☐ CALL

When were you first diagnosed with Low Bone Mass (osteopenia/osteoporosis)?_____
Are you up and on your feet at least four hours per day? YES NO What do you currently do for fitness/exercise? _____
How many hours do you spend sitting in a day? Reading_____ Watching TV_____ Playing Cards_____ Handwork_____ Other_____
Do you have difficulty with any of these activities: ☐ Getting in/out of bed ☐ Standing up from a chair ☐ Dressing
☐ Puzzles ☐ Knit/Crochet ☐ Painting ☐ Other_____

Present: Weight _____ Height _____ft. _____in.
Tallest recalled Height _____ft. _____in.
Do you have Pace Maker? YES NO

Have you fallen in the last 3mo.? YES NO
Have you fallen in the last 12mo.? YES NO
Did you sustain any injuries from a fall in the last year? YES NO
Do you get dizzy/lightheaded? YES NO

Regarding broken bones - Please check any that apply to you - List date of fracture if available also.
☐ Hip Fracture _____ ☐ Spinal Compression Fracture _____ ☐ Wrist Fracture _____
☐ Other:_____ ☐ Hip Fracture in immediate family _____

Women: (Please check all that apply) ☐ Post Menopausal (Natural or Surgical) ☐ Early Menopause (before age 45) ☐ Short Fertile Period (fewer than 30 years) ☐ Late Menarche (after age 14)

Men: (Please check all that apply) ☐ Over age 70 years ☐ Low Testosterone

Please check any of the following that apply to you:

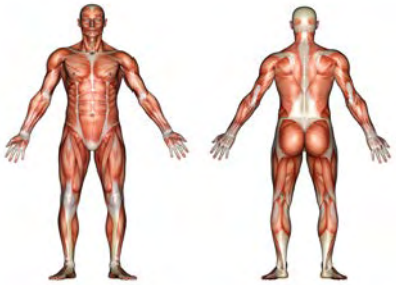
- ☐ Malabsorbtion Syndrome
- ☐ Diabetes Type I or II
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Mental Illness
- ☐ Depression
- ☐ Scoliosis
- ☐ Leukemia or Lymphoma Anemia
- ☐ Burns
- ☐ Pernicious Anemia
- ☐ Back Pain
- ☐ Visual Problems
- ☐ Emphysema/COPD
- ☐ Rheumatoid Arthritis
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Neurological Disorders
- ☐ Sickle Cell Disease
- ☐ Kidney Dialysis
- ☐ Cancer - _____
- ☐ Chronic Inflammation
- ☐ Cushing's Disease
- ☐ Loss of Teeth
- ☐ Transparent/Fragile Skin
- ☐ Postural Changes
- ☐ Family History of Osteoporosis
- ☐ Alcohol Use ___Drinks/Day ___Drinks/Week
- ☐ Cigarette Use ___Packs/Day and How Long_____
- ☐ High Caffeine Intake (more than 3 cups/day)
- ☐ Low Calcium Diet
- ☐ Low Sun Exposure
- ☐ Physically Inactive
- ☐ Prolonged Immobilization
- ☐ Over-Exerciser
- ☐ Eating Disorder_____
- ☐ Low Body Weight

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

If you have pain, please mark on the picture locations of pain:



Have you noticed increased pain in any body part? YES NO

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

Current Medications: (Name/Dosage/Frequency/Route Administered)

_____
_____
_____

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

Are you taking, or have you taken, any of the following medications? (check all that apply):

- ☐ Corticosteroids
- ☐ Diuretics
- ☐ Antacids with Aluminum
- ☐ Coumadin
- ☐ Cyclosporine A
- ☐ Methotrexate
- ☐ Lithium
- ☐ Depo-Provera
- ☐ Thyroid
- ☐ Antiseizure Meds (Dilantin, Pehobarbitol)
- ☐ Anti-Rejection Drugs
- ☐ Selective Serotonin Reuptake Inhibitors (Zoloft, Prozac, Lexapro)
- ☐ Gonado-Releasing Hormones
- ☐ Tamoxifen (premenopausal use)
- ☐ Cholestryramine
- ☐ Proton Pump Inhibitor (e.g. Nexium, Prevacid, Prilosec).
- ☐ Aromatase Inhibitors (e.g. Arimidex, Aromasin, Femara)
- ☐ Heparin

Is there anything else you would like to tell me that you think would help me treat you?_____
_____