FYZICAL®
THERAPY AND BALANCE CENTERS
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.

● **INITIALS: _____**

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®

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):

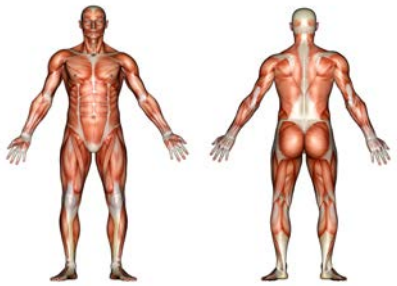
- ☐ Fatigue
- ☐ Pregnant
- ☐ Fever/Night Sweats
- ☐ Shortness of breath
- ☐ Ear Pressure/Pain
- ☐ Head Injury/Concussion
- ☐ Persistent pain at night
- ☐ Swelling/Lymphedema
- ☐ Problems with coordination
- ☐ Sudden weakness or fainting
- ☐ Problems with swallowing or speech
- ☐ Unexplained weight loss 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
- ☐ Depression
- ☐ Other 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. Are you taking prescription medication for this condition? YES NO
4. How many surgeries have you had for the problem which you are being treated?
   ☐NONE ☐1 ☐2 ☐3 ☐4 or more
5. 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