



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: (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:

Dizziness Handicap Inventory Questionnaire

Name: _____ DOB: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no" or "some" (sometimes affected) to each question. *Answer as it applies to your dizziness or unsteadiness only.*

Does looking up increase your problem?	Yes	Some	No
Because of your problem, do you feel frustrated?	Yes	Some	No
Because of you problem, do you restrict your travel for business or recreation?	Yes	Some	No
Does walking down the aisle of a supermarket increase your problem?	Yes	Some	No
Because of your problem, do you have difficulty getting into or out of bed?	Yes	Some	No
Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing or to parties?	Yes	Some	No
Because of your problem, do you have difficulty reading?	Yes	Some	No
Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Some	No
Because of your problem, are you afraid to leave your home without someone accompanying you?	Yes	Some	No
Because of your problem, have you been embarrassed in front of others?	Yes	Some	No
Do quick movements of your head increase your problem?	Yes	Some	No
Because of your problem, do you avoid heights?	Yes	Some	No
Does turning over in bed increase your problem?	Yes	Some	No
Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Some	No
Because of your problem, are you afraid people may think you are intoxicated?	Yes	Some	No
Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Some	No
Does walking down a sidewalk increase your problem?	Yes	Some	No
Because of your problem, is it difficult for you to concentrate?	Yes	Some	No
Because of your problem, is it difficult for you to walk around your house in the dark?	Yes	Some	No
Because of your problem, are you afraid to stay home alone?	Yes	Some	No
Because of your problem, do you feel handicapped?	Yes	Some	No
Has your problem placed stress on you relationships with members of your family or friends?	Yes	Some	No
Because of your problem, are you depressed?	Yes	Some	No
Does your problem interfere with your job or household responsibilities?	Yes	Some	No
Does bending over increase your problem?	Yes	Some	No

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

Do you have a Pace Maker: YES NO 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):

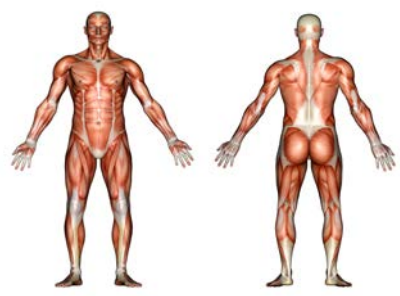
Please mark on the picture locations of pain:

- 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



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:

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):

- 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 _____

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