FYZICAL®
Therapy & Balance Centers

Spelled Different Because We Are Different!

For Office Use Only: Initial Evaluation
Date: ____/____/_____
Time: _____
Therapist: _____

PATIENT MEDICAL HISTORY

Date: _____/_____/_____ Date of Birth:____/____/____ **Age:** _____ **Height**_____ **Weight**_____
Name:_____ Referring Physician: _____
Social Security No:_____-____-_____
Local Address: _____ Out of State Address: _____
City _____ State:_____ Zip: _____ City:_____ State:_____ Zip: _____
Phone: (_____)-_____
Email: _____ Alt Phone:(_____)_____-_____
Emergency Contact: _____ Phone: (____)_____-_____

How would you like to receive automated REMINDERS for future appts? Email ____ Phone _____ Text _____

How did you hear about us?(check all that apply) Doctor: _____ Walk-in/Self: _____ Friend: _____ Other:_____

What is your main complaint:_____ What body part?_____

What are your goals for therapy? _____

Date of injury/onset of this condition? _____ Date of Surgery _____

Have you recently had Home Health? If yes, company name _____ Discharge date:_____

Are you currently receiving Chiropractic Care? Yes_____ No _____

Have you ever had any of the following medical or rehab services for this injury? (Please check what applies)
Chiropractor ____ EMG/NCV ____ Massage Therapy ____ Myelogram ____ Occupational Therapy ____
Physical Therapy ____ Emergency Room Care ____ CT Scan ____ General Practitioner ____ MRI ____
Neurologist ____ X-Ray ____ Orthopedist ____ Podiatrist ____ Other _____

Do you have or ever had any of the following? (Please check what applies)

____ Asthma
____ Emphysema
____ Shortness of Breath
____ Chest Pain
____ Pacemaker / Defibrillator
____ High Blood Pressure
____ Heart Attack or Surgery
____ Stroke / TIA
____ Heart Problems
____ Blood Clot / Emboli
____ Thyroid Trouble / Goiter
____ Anemia
____ Infectious Disease
____ Cancer or Chemo / Radiation
____ Uncontrolled Leakage of Urine
____ Loss of Bowel Control
____ Osteoarthritis
____ Osteoporosis
____ Epilepsy / Seizures
____ Severe / Frequent Headaches
____ Hearing Problems
____ Vision Problems
____ Numbness or Tingling
____ Dizziness
____ Fainting
____ Weakness
____ Lung Disease
____ Varicose Veins
____ Joint Replacements
____ Any Pins / Metal Implants
____ Neck Injury / Surgery
____ Back Injury / Surgery
____ Currently Pregnant
____ Tobacco Use
____ Alcohol Use
____ Psychological Problems
____ Rheumatoid Arthritis
____ Diabetes

Continue on next page

1. Dominant Hand: **L / R.** Trouble side: **L / Center / R**

Symptoms started **gradually** or **abruptly**? _____

2. What impairment brings you to therapy (be specific) _____

3. How did injury occur **or** symptoms begin? _____

4. Have symptoms changed since onset? **Y or N** Any previous similar symptoms? **Y** or **N**

5. Any previous treatment? **Y or N** Helpful? **Y or N** Chiropractor: **Y or N**

****Pain: 0 = No Pain 10 = Excruciating Pain which requires emergency care in the E.R.****

6. Today's Pain: 0 1 2 3 4 5 6 7 8 9 10.

7. Pain at Worst: 0 1 2 3 4 5 6 7 8 9 10. At Best: 0 1 2 3 4 5 6 7 8 9 10

8. Superficial/Deep Intermittent/Constant Type of pain: Sharp/Dull/Achy/etc. _____

9. Is there a time of the day your pain is worse? _____ Better? _____

10. What positions/activities **Increase** your symptoms (Circle all that apply): Lying Sitting Sit-Stand Stand Walking Running Lifting Bending Up-Stairs Down-Stairs Other: _____

11. What positions/activities **Decrease** your symptoms (Circle all that apply): Lying Sitting Sit-Stand Stand Walking Running Lifting Bending Ice Heat Massage Meds Other: _____

12. If you have back/neck pain: does coughing/sneezing worsen symptoms? **Y** or **N**

13. If you have back/neck pain: do symptoms/pain radiate into arms/legs? **Y or N**

- If yes, describe radiating pain: _____

14. Experienced any **unexpected** weight loss recently? **Y** or N. Pain worse after eating? **Y** or N

15. Recent results of: X-ray (if any) _____

MRI: _____

Other Treatment: _____

16. Previous Major Surgeries: _____

17. Any Major illnesses/conditions? _____

18. Current limitations affecting daily activities: _____

19. List Medications currently taking: _____

_____

20. Have you fallen in the past 12 months? **Y** or **N** Did you incur an injury? **Y** or **N**

What do YOU WANT TO achieve from having therapy? Check all that apply:

___ Improve home activities ___ Improve mobility/walking activities ___ Improve self care activities

___ Return to work ___ Decrease or eliminate pain/discomfort ___ Improve leisure/sports activities

To the best of my knowledge, the above information is complete and factual.

_____ _____

Patient Signature Date

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Patient Acknowledgement Form

Please 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 filing 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 expect or should you have any questions regarding your insurance plan benefits, please contact them directly.

_____ I authorize the ***release of information*** acquired in the course of my treatment, including but 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 messages*** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ A copy of this facility's ***Notice of Information/ Privacy Practices*** has been provided to me.

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

_____ A $35.00 fee will be charged for 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 dependents. I understand I am responsible for any amount not covered by 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 Date

_____ _____
Patient Legal Representative Date

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Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed as well as how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other governmental requests
- Respond to lawsuits and legal actions

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Patient Name

___/___/_____
Date

MEDICARE QUESTIONNAIRE

Medicare Beneficiaries Over 65

1. Are you currently working full or part-time? Yes _____ No _____
2. Are you married? Yes _____ No _____
3. Is your spouse working full or part-time? Yes _____ No _____
4. If yes, how many employees does you employer or your spouse's employer have? Yes _____ No _____
5. Are you coveredunder an employer group health plan based on your current employment, or current employment of a spouse? Yes _____ No _____
6. Are you entitled to Black Lung Medical Benefits? (i.e. As a result of working in a coal mine.) Yes _____ No _____
7. Was this service for the treatment of a work-related injury? Yes _____ No _____
8. Was this service for the treatment of an illness or injury which resulted from an auto/other accident? Yes _____ No _____
9. Are the services to be paid by a government program such as a research grant? Yes _____ No _____
10. 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 od 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 _____

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Disclaimer for Medicare Patients

Have you had any Home Health Care in the last 60 days?

YES NO

If yes, last date of service: _____

Name of Agency: _____

Telephone Number of Agency: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

For Office Use Only

_____ Called Home Health Agency to confirm discharge date

_____ Spoke to _____ at _____
Name Time

_____ Patient discharged _____
Date

_____ Patient will be discharged

_____ Other _____

_____

Client Name: _____

Date: _____

Case #: _____

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Client Health Questionnaire

☆ 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