FYZICAL™
Therapy & Balance Centers

Patient Intake Questionnaire

NAME:_____DATE OF BIRTH:_____

ADDRESS: _____

CITY:_____STATE:_____ZIP CODE:_____

PHONE #:_____WORK PHONE#:_____

EMAIL:_____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE:_____

EMERGENCY CONTACT– NAME:_____
PHONE #:_____RELATIONSHIP_____
PRIMARY CARE PHYSICIAN:_____

CONSENT FOR TREATMENT: I hereby consent to receive care for therapy services by FYZICAL™. I consent to medical treatment as is deemed necessary or advised by the physical therapist.

LIABILITY RELEASE: I hereby accept the responsibility for any harm, injury, or damage that may result from my participation in physical therapy services. I hereby waive, release, absolve, indemnify, and agree to hold harmless FYZICAL THERAPY & BALANCE CENTERS; its officers, employees, students and affiliates for any claim arising out of any injury to me, whether the result of negligence or any cause. I voluntarily and knowingly acknowledge, accept and assume these risks.

CONSENT TO RELEASE MEDICAL INFORMATION: I authorize FYZICAL[tm] to release any information acquired in connection with my therapy services including but not limited to diagnosis, clinical records, to myself , my insurance, physician, and _____.

CONSENT TO OBTAIN MEDICAL INFORMATION: I authorize FYZICAL[tm] to obtain and acquire medical information that would be beneficial in connection to my therapy services including but not limited to x-rays, MRI, CAT scans, and physicians records.

NOTICE OF PRIVACY PRACTICES/ HIPAA: I have read and understand my rights under the Health Insurance Portability and Accountability Act.

ATTENDANCE POLICY: It is important that you make every attempt to keep your scheduled appointments. However, if you need to cancel an appointment please provide a **24 hour notice**. Failure to do so will result in a **$50 cancellation fee or No Show Fee.** Appointment times are reserved specifically for you and your individual needs as a patient/client. Appointment times are allocated on a first come, first serve basis and failure to give proper notice causes other patients to be denied valuable appointment times.

****IF MINOR:** Responsible party:_____Relationship:_____

I HEREBY CERTIFY THAT I UNDERSTAND THESE RIGHTS AS SET FORTH.

Patient/ Responsible Party Signature:_____

Date:_____

EXPLAINATION OF BENEFITS AND FINANCIAL RESPONSIBILITY

As a courtesy, we contacted your insurance company and the following benefit information was quoted. Please be aware that your insurance provided this information solely as a quote and you as a patient should contact your insurance provider directly to confirm or dispute the quoted information. Ultimately, this information is a quote and it does not guarantee payment.

Your insurance company has quoted the following information:

DEDUCTIBLE_____ **PORTION MET**_____

COPAYMENT_____ **COINSURANCE**_____

MAXIMUM VISITS PER YEAR_____

FINANCIAL POLICY ACKNOWLEDGEMENT:

I have read and understand the above financial information. I understand that regardless of my insurance claim status, quotes given and/or absence of insurance coverage, I am ultimately responsible for the balance on my account for services rendered.

WORKERS COMPENSATION/ AUTO INSURANCE/ INJURY INFORMATION

(Please complete if injury is related to a work or auto):

DATE OF INJURY/ONSET OF PAIN_____ **TYPE OF ACCIDENT: AUTO**_____ **JOB**_____

CONTACT PERSON:_____ **CLAIM #**_____

Patient or Responsible Party Signature:_____ **Date:**_____

PLEASE CHECK THE FOLLOWING THAT YOU HAVE OR HAVE HAD:

_ALLERGIES	_COLD HANDS OR FEET	_EPILEPSY	_LUNG DISEASE
_ANEMIA	_CONSTIPATION	_HEART ATTACK	_LOW BLOOD PRESSURE
_ASTHMA	_CURRENTLY PREGNANT	_HEART DISEASE	_METAL IMPLANTS
_CANCER	_DIABETES	_HIGH BLOOD PRESSURE	_NAUSEA
_CHEST PAIN	_DISC PROBLEMS	_KIDNEY PROBLEMS	_OPEN WOUNDS
_CIRCULATORY ISSUES	_EAR DISORDERS	_KIDNEY STONES	_OSTEOARTHRITIS
_OSTEOPOROSIS	_SKIN SENSITIVITY	_THYROID PROBLEMS	_LIVER DISEASE
_RHEUMATOID ARTHRITIS	_STROKE	_BOWEL/ BLADDER ISSUES	_GALLBLADDER PROLEMS
_PACEMAKER	_TUBERCULOSIS	_STOMACH PROBLEMS	_VOMITING
_RADIATION TREATMENT IN LAST 3 MONTHS			
OTHER :			

PLEASE ANSWER YES OR NO FOR THE FOLLOWING:

Have you had a fall in the past year?_____

Do you have a fear of falling?_____

Would you like balance to be assessed?_____

Do you experience dizziness or imbalance_____

Do you lose your balance when stepping up or down curbs or stairs/steps?_____

Do you have a difficult time walking in the dark?_____

Do you have difficulty hearing?_____

Do you have any other concerns that you would like to be addressed while receiving physical therapy?_____

_____

If there is any information you would like us to know about you please feel describe below_____

_____

Thank you for choosing us for your physical therapy needs! We truly look forward to working with you and helping you **LOVE YOUR LIFE.**

Present Condition

What condition or concern has brought you here?_____

Is this condition associated with a surgery?_____If Yes, what and when was the surgery_____

When did this condition begin or recently worsen?_____

Was there a direct cause to this condition?_____

Have you been treated for this condition before?_____If Yes, when?_____

Does this condition affect your daily activities or social life?_____If Yes, please describe_____

_____

What makes it worse_____and What makes it better_____

Are you currently receiving treatment for this condition with another healthcare specialist or physician?_____

If Yes, whom?_____

PLEASE CHECK YOUR PRESENT SYMPTOMS:

__HEADACHE	_MID BACK PAIN	__MUSCLE JERKING	__ANXIETY
__NECK PAIN	_MID BACK STIFFNESS	__MUSCLE SPAMS	_PANIC ATTACKS
__NECK STIFFNESS	_LOW BACK PAIN	__MUSCLE SORENESS	_TENSION
__MEMORY LOSS	_LEG PAIN L / R	__BLURRED VISION	_IRRITABILITY
_SHOULDER PAIN L / R	_LEG TINGLING L / R	__BUZZING/ RINGING IN EARS	_DIFFICULTY SLEEPING
_SHOULDER STIFFNESS	_LEG NUMBNESS L / R	__DIZZINESS	__DIFFICULTY BREATHING
_ARM TINGLING L / R	_BALANCE CONCERNS	__FAINTING	OTHER :
_ARM NUMBNESS L / R	_FATIGUE	__DIFFICULTY BREATHING	

General Health and Past Medical History

ıre you currently taking any medication or dietary supplements?_____. If Yes, what and for what reason _____

_____

_____

_____

'revious operations, hospitalizations, chronic illness, injuries?_____Please describe area of body and when_____

_____

_____

)o you smoke_____ If Yes, how many cigarettes a day_____.

)o you exercise_____.If Yes, how many times a week_____, how long (mins or hours)_____

)n a special diet_____, If Yes, please describe_____

'rior to your recent condition, were you participating in any sports, activities or hobbies on a regular basis?_____If Yes, what?___

_____

Vhat goals do you want to achieve through treatment?_____

_____