BALANCE rehabilitation
PHYSICAL THERAPY • VESTIBULAR • ORTHOPEDIC • NEUROLOGIC

PATIENT INFORMATION

NAME	SEX ☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH

ADDRESS

CITY STATE ZIP CODE

BILLING ADDRESS (if different from above)

PHONE Please check the number you prefer to be called at

☐ HOME ( ) _____

☐ CELL ( ) _____

☐ WORK ( ) _____

REFERRED BY:

☐ DOCTOR _____

☐ FRIEND _____

☐ OTHER _____

EMAIL ☐ I prefer appointment reminders be sent to my email

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT INFORMATION

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY STATE ZIP CODE

PHONE

FINANCIALLY RESPONSIBLE PARTY
(IF OTHER THAN PATIENT)

NAME

DOB RELATIONSHIP TO PATIENT

ADDRESS

CITY STATE ZIP CODE

PHONE

IS THE CONDITION WE ARE SEEING YOU FOR RELATED TO:

IS CONDITION SURGERY RELATED? ☐ YES ☐ NO	DATE OF SURGERY:	SURGICAL PROCEDURE:
IS CONDITION MVA RELATED? ☐ YES ☐ NO	DATE OF AUTO ACCIDENT:	DESCRIBE ACCIDENT/INJURY/ILLNESS:
IS CONDITION WORK COMP. RELATED? ☐ YES ☐ NO	DATE OF INJURY:	ARE YOU CURRENTLY WORKING? ☐ YES ☐ FULL-TIME ☐ PART-TIME ☐ NO

NAME OF EMPLOYER AT TIME OF INJURY: CITY STATE ZIP CODE

IS LITIGATION (LAWSUIT) INVOLVED? ☐ YES ☐ NO	NAME OF ATTORNEY:	PHONE #

Are you currently or have you recently received ANY healthcare services through a Home Health Agency (HHA)?

☐ Yes ☐ No **If yes, please provide the following information:**

Name of Home Health Agency: _____

Phone: _____ Date of discharge from Home Health Agency: _____

All services furnished are charged directly to the patient. Patients are financially responsible for payment unless other arrangements have been made with the office management. It is our policy that payment be made at the same time services are rendered. We do not render services on the basis that insurance companies are financially responsible.

CONSENT FOR TREATMENT

I hereby authorize my consent to be treated now and in the future by Balance Rehabilitation.

PATIENT / INSURED SIGNATURE DATE

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Orthopedic Patient History

Name: _____ **Date:** _____

Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____

Date of injury, onset of symptoms, or surgery: _____

Please list any conditions that you would like to address with the Physical Therapist and how often you experience them:

_____

_____

Please list your goals in coming to physical therapy:

_____

_____

List any providers you have seen (name & specialty) or treatments you have had for the above conditions:

_____

_____

List any testing (labs, MRI, CT, VNG) you have had for the above condition:

_____

What is the intensity of your symptoms?

At worst: 0 1 2 3 4 5 6 7 8 9 10
None Moderate Severe

Current: 0 1 2 3 4 5 6 7 8 9 10
None Moderate Severe

At best: 0 1 2 3 4 5 6 7 8 9 10
None Moderate Severe

Worse in: Morning Afternoon Night

What is the nature of your symptoms? (Circle all that apply)

Numbness Tingling Shooting Burning

Throbbing Sharp Dull Achy Weakness

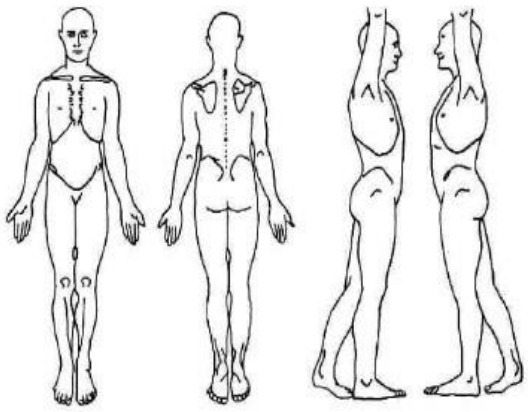
Constant Intermittent

If you are experiencing pain:
Pain increases during:

_____

Pain decreases during:

_____



Please indicate where your pain is located

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Name: _____ **Date:** _____

Please Indicate if you have or have had any of the following conditions: (Check all that apply)

- ☐Alcoholism
- ☐Allergies/Asthma
- ☐Angina/Chest Pain
- ☐Anxiety/Stress
- ☐Bowel or Bladder Problems
- ☐Changes in Appetite
- ☐Dementia/Alzheimer's Disease
- ☐Depression
- ☐Diabetes (I or II)
- ☐Difficulty Sleeping
- ☐Fainting
- ☐Falls
- ☐Fibromyalgia
- ☐Frequent Loss of Balance
- ☐Hard of Hearing/Hearing Aid
- ☐Headaches/Migraines
- ☐Heart Disease
- ☐Hernia
- ☐High/Low Blood Pressure
- ☐History of Cancer
- ☐HIV Positive/AIDS/Hepatitis
- ☐Joint Replacement
- ☐Lightheadedness/Dizziness
- ☐Lupus
- ☐Memory Loss
- ☐Nausea/Vomiting
- ☐Obesity
- ☐Osteoarthritis
- ☐Osteoporosis
- ☐Pacemaker
- ☐Parkinson's/Huntington's
- ☐Pregnant (Currently)
- ☐Recent Excessive Weight Loss
- ☐Rheumatoid Arthritis
- ☐Seizures
- ☐Shortness of Breath
- ☐Smoking Tobacco
- ☐Stroke/TIA
- ☐TBI/History of Concussions
- ☐Vision (Glasses or Contacts)
- ☐ Autoimmune
- ☐Cardiac
- ☐Neurological

Please List any other medical conditions, surgeries, or health concerns not listed above:

_____

_____

Have you fallen? Yes / No

If yes, have you had 2 or more falls in the last year? Yes / No

If yes, have you had any fall with injury in the last year? Yes / No

_____ _____

Signature of Patient Date

_____ _____

Signature of Physical Therapist Date

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Medication List

Name: _____ **Date:** _____

☐ **See Attached**

Medication Name	What condition is it for?

Have there been any recent changes in your medication? Yes / No

If so, please list:_____

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Shoulder Pain and Disability Index

Patient Name: _____ Date: _____

SECTION I:
Please rate your pain level with activity: *NONE = 0 1 2 3 4 5 6 7 8 9 10 = SEVERE*

SECTION II: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply in the last week.**

Pain Scale

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

How severe is your pain…

1. At its worst?: 0 1 2 3 4 5 6 7 8 9 10
2. When lying on the involved side?: 0 1 2 3 4 5 6 7 8 9 10
3. Reaching for something on a high shelf?: 0 1 2 3 4 5 6 7 8 9 10
4. Touching the back of your neck?: 0 1 2 3 4 5 6 7 8 9 10
5. Pushing with the involved arm?: 0 1 2 3 4 5 6 7 8 9 10

Disability Scale

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it requires help

How much difficulty do you have…

1. Washing your hair?: 0 1 2 3 4 5 6 7 8 9 10
2. Washing your back?: 0 1 2 3 4 5 6 7 8 9 10
3. Putting on an undershirt or pullover sweater?: 0 1 2 3 4 5 6 7 8 9 10
4. Putting on a shirt that buttons down the front?: 0 1 2 3 4 5 6 7 8 9 10
5. Putting on your pants?: 0 1 2 3 4 5 6 7 8 9 10
6. Placing an object on a high shelf?: 0 1 2 3 4 5 6 7 8 9 10
7. Carrying a heavy object of 10 pounds?: 0 1 2 3 4 5 6 7 8 9 10
8. Removing something from your back pocket?: 0 1 2 3 4 5 6 7 8 9 10