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

BALANCE rehabilitation
PHYSICAL THERAPY • VESTIBULAR • ORTHOPEDIC • NEUROLOGIC

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

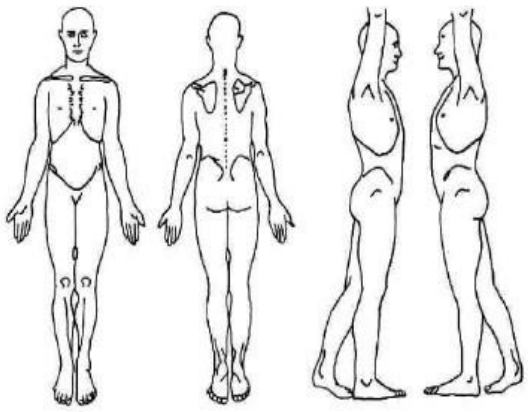
Constant Intermittent

If you are experiencing pain:
Pain increases during:

_____

Pain decreases during:

_____



Please indicate where your pain is located

BALANCE rehabilitation
PHYSICAL THERAPY • VESTIBULAR • ORTHOPEDIC • NEUROLOGIC

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

BALANCE rehabilitation
PHYSICAL THERAPY • VESTIBULAR • ORTHOPEDIC • NEUROLOGIC

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:_____

BALANCE rehabilitation
PHYSICAL THERAPY • VESTIBULAR • ORTHOPEDIC • NEUROLOGIC

Neck 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*
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 Intensity
□ I have no pain at the moment.
□ The pain is very mild at the moment.
□ The pain is moderate at the moment.
□ The pain is fairly severe at the moment.
□ The pain is very severe at the moment.
□ The pain is the worse imaginable at the moment.

Personal Care (washing, dressing, etc)
□ I can look after myself normally without extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self-care.
□ I cannot get dressed, I wash with difficulty and I stay in bed.

Lifting
□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it gives me extra pain.
□ Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
□ Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
□ I can lift only very light weights.
□ I cannot lift or carry anything at all.

Headache
□ I have no headaches at all.
□ I have slight headaches which come infrequently.
□ I have moderate headaches which come infrequently.
□ I have moderate headaches which come frequently.
□ I have severe headaches which come infrequently.
□ I have headaches almost all the time.

Recreation
□ I am able engage in all my recreational activities without pain.
□ I am able to engage in my recreational activities with some pain
□ I am able to engage in most but not all of my usual recreational activities because of my neck pain.
□ I am able to engage in a few of my usual recreational activities with some neck pain.
□ I can hardly do any recreational activities because of neck pain.
□ I can't do any recreational activities at all

Reading
□ I can read as much as I want with no pain in my neck.
□ I can read as much as I want with slight neck pain.
□ I can read as much as I want with moderate neck pain.
□ I can't read as much as I want because of moderate neck pain.
□ I can hardly read at all because of severe neck pain.
□ I cannot read at all because of neck pain.

Work
□ I can do as much as I want to.
□ I can only do my usual work but no more.
□ I can do most of my usual work but no more.
□ I cannot do my usual work.
□ I can hardly do any usual work at all.
□ I cannot do any work at all.

Sleeping
□ Pain does not prevent me from sleeping well.
□ My sleep is slightly disturbed (<1 hr. sleep loss).
□ My sleep is mildly disturbed (1-2 hr. sleep loss).
□ My sleep is moderately disturbed (2-3 hr. sleep loss).
□ My sleep is greatly disturbed (3-4 hr. sleep loss).
□ My sleep is completely disturbed (5-7 hr. sleep loss).

Concentration
□ I can concentrate fully when I want with no difficulty.
□ I can concentrate fully when I want with slight difficulty.
□ I have a fair degree of difficulty concentrating when I want.
□ I have a lot of difficulty concentrating when I want.
□ I have great difficulty concentrating when I want.
□ I cannot concentrate at all.

Driving
□ I can drive my car without neck pain.
□ I can drive my car as long as I want with slight neck pain.
□ I can drive my car as long as I want with moderate neck pain.
□ I can't drive my car as long as I want because of moderate pain.
□ I can hardly drive my car at all because of severe neck pain.
□ I can't drive my car at all.