BVC Physical Therapy

PATIENT REGISTRATION

Name _____ Date _____
Last First MI

Mailing Address _____
Street City State Zip Code

Physical Address _____
Street City State Zip Code

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

Contact Preference: ☐ Home ☐ Work ☐ Cell E-mail Address _____

Social Security Number _____ Birth date _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner; Registered in: _____ Spouse/Partner's Name _____ ☐ Divorced ☐ Widowed

Employer _____ Employer's Address _____

Primary Care Physician _____ Referring Physician _____

Emergency Contact _____ Relationship _____

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

Primary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other State in which injury occurred _____

Claim Number _____ Insurance Company (worker's comp or your auto PIP) _____

Address _____ Claims Adjuster _____ Phone number _____

I verify that the above information is accurate (Signature) _____

Please tell us how you learned of our service or whom we can thank

☐ I was a **Former Patient**
☐ **Former Patient** recommendation
☐ **Health Club/Professional** recommendation
☐ **Family/Friend/Co-Worker** recommendation
☐ **Doctor** recommendation
☐ **Radio** advertisement
☐ **Yellow Page** advertisement
☐ Found you on the **Internet**
Website: _____
☐ **TV/Billboard** advertisement
☐ **Publication/Newspaper** advertisement
Publication: _____
☐ **Clinic Sign**
☐ Saw you at an **Event**
Event: _____

BALANCE-MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Date: _____

HISTORY OF PRESENT CONDITION

1. Primary concern/reason for referral: _____
2. Symptoms: Check yes **(Y)** or no (**N)**

Symptom	Y	N	Symptom	Y	N
Spinning sensation			Hearing loss		
Lightheadedness			Ringing in ears		
Sense of floating, rocking, tilting			Pain/pressure in ears		
Dizziness when standing up quickly			Severe or recurrent headaches		
Difficulty walking			Neck pain		
Unsteadiness			Weakness/clumsiness in arms/legs		
Numbness/tingling in feet			Fatigue		
Nausea and/or vomiting			Brain fog		
Visual disturbances (double, blurry)			Confusion/memory loss		

3. When did your problem start? (date): _____

4. Was it associated with a specific event (e.g. head injury, car accident, fall)? ☐ Yes ☐ No
If yes, please explain: _____

5. Since onset, has your problem: ☐ worsened ☐ improved ☐ stayed the same

6. Which of the following are you having difficulty with? (Check all that apply)

√	Activity/Situation	√	Activity/Situation
	Negotiating curbs and stairs		Getting in/out of a car
	Walking over uneven surfaces		Getting up/down from a chair
	Walking in dimly lit environments		Walking without veering
	Walking and turning head		Bending over/squatting
	Walking in narrow or crowded places		Closing eyes in the shower or when washing face
	Walking without tripping/dragging feet		Turning or changing directions quickly
	Walking and multitasking (e.g, carrying something in hand or having a conversation)		Other (describe):
	Getting dressed/undressed		

7. Fall History:
   Have you ever fallen? ☐ Yes ☐ No
   How many falls have you had in the past year? _____
   When was your most recent fall? Date: _____

8. Do you use any assistive device? Check all that apply: ☐ walker ☐ cane ☐ wheelchair ☐ scooter ☐ none
   Which environment do you use the assistive device? ☐ home ☐ community/long distances ☐ traveling

9. What activities are you not able to do because of your imbalance (e.g., hobbies, household chores?)
_____

Past Medical History

Check yes **(Y)** or no (**N**):

Diagnosis	Y	N	Diagnosis	Y	N
Cancer: (type:_____)			Seizures		
Depression			Osteoporosis or Osteopenia		
Anxiety			Arthritis		
Stroke or TIA			Diabetes (Type 1 or Type 2) Insulin dependent? ☐ Yes ☐ No		
Migraines (including ocular migraines)			Vision problems (macular degeneration, cataracts, glaucoma)		
Concussion			Atrial fibrillation		
Multiple Sclerosis			Pacemaker/defibrillator		
Parkinson's Disease			Blood pressure problems (Circle: High or Low or Fluctuating)		
Neuropathy			Difficulty breathing/shortness of breath		
Whiplash or neck injury			Viral Infection (e.g, COVID-19)		
Back pain			Other (please specify):		
High Cholesterol					

Surgical History (Type/Date)

_____

_____

Medication

Please list any prescription medications you take: (if you have a list, please attach copy)

_____

Relevant Diagnostic Testing and Treatment

Have you seen other healthcare providers for your current condition? ☐ Yes ☐ No

If yes, who? ☐ Primary care doctor ☐ ENT ☐ Neurologist ☐ Cardiologist ☐ Emergency room Other: _____

Have you had any of the following done for your current condition?

√	Test/Therapy	Date	Results (if you have results, please attach copy)
	ENG/VNG		
	CT scan or MRI		
	Hearing Test		
	Rehabilitation (PT or OT)		Did it help? ☐ Yes ☐ No

Social History and Habits

1. Occupation: (if applicable) _____ ☐ full-time ☐ part-time ☐ unemployed ☐ disabled ☐ retired
2. Living situation: ☐ live alone ☐ live with family ☐ live with caregiver ☐ live in assisted living
3. Do you have steps or stairs in your home? ☐ Yes ☐ No If yes, how many? _____
4. Do you smoke? ☐ Yes ☐ No If yes, how much per day: _____
5. Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how much (e.g, cups/ounces): _____
6. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much (e.g, cups/ounces):_____How often (e.g, daily, per week): ____
7. Current activity level: ☐ inactive ☐ light ☐ moderate ☐ vigorous List activities/hobbies: _____
8. Prior activity level: ☐ inactive ☐ light ☐ moderate ☐ vigorous List activities/hobbies: _____
9. Are you currently receiving or seeking disability for your condition? ☐ Yes ☐ No
10. What are your goals for physical therapy? _____

Patient Name: _____ Date: _____

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants: For each of the following activities, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100% If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports.

0%	10	20	30	40	50	60	70	80	90	100%
No Confidence										Completely Confident

How confident are you that you will not lose your balance or become unsteady when you…

1. …walk around the house? _____%
2. …walk up or down stairs? _____%
3. …bend over and pick up a slipper from the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tip toes and reach for something above your head? _____%
6. …stand on a chair and reach for something? _____%
7. …sweep the floor? _____%
8. …walk outside the house to a car parked in the driveway? _____%
9. …get into or out of a car? _____%
10. …walk across a parking lot to the mall? _____%
11. …walk up or down a ramp? _____%
12. …walk in a crowded mall where people rapidly walk past you? _____%
13. …are bumped into by people as you walk through the mall? _____%
14. …step onto or off of an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. …walk outside on icy sidewalks? _____%

*Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1):M28-34.

Total ABC Score: _____

Scoring: _____ / 16 = _____% of self confidence
Total ABC Score

MEDICARE PATIENTS ONLY
100% - _____% Function = _____% Impairment

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

"NO SHOWS" AND CANCELLATIONS

Please Read Carefully

In order to ensure that our patients receive timely therapeutic services, Balance & Vestibular Center Physical Therapy has instituted an appointment cancellation/"no show" policy for all physical therapy appointments. Please read the policy below and sign in the space provided.

At BVC Physical Therapy your appointment time is specifically reserved for you and you alone. We believe that to provide the highest level of care, no other patients should be seen by your therapist at your scheduled time. A late cancellation or no show affects our business and your care in three ways. Firstly, you are not receiving the prescribed care to benefit your condition. Second, our therapist now has a full hour with no patient to see and thirdly, a patient, who may have needed to be seen at that time, is unable to receive the care they need.

"NO SHOW"/CANCELLATION POLICY
In today's hectic world, unplanned issues come up for all of us. At BVC Physical Therapy, we will gladly reschedule your appointment up until 24 hours before your appointment. In other words, you must cancel your scheduled appointment by calling us a minimum of 24 hours in advance. That way, the open slot can be filled with someone needing an appointment.

Cancellation Fees: Failure to provide the required 24 hours notice will result in missed appointment fees. These fees are not covered by insurance carriers or Medicare and will be your responsibility to pay before or at the time of your next visit.

$50 fee for a "no show" or cancelling less than 24 hours in advance.

Possible Discharge from Physical Therapy: Three consecutive "no-shows" will result in automatic discharge from physical therapy due to non-compliance with your treatment plan.

The BVC Physical Therapy cancellation/"no show" policy is designed to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated.

I, _____ agree to comply with this Cancellation/"No Show" Policy.
(please print name)

_____ _____
Signature (patient or guardian) Date

BVC
Physical Therapy
Patient Authorization Record

Initial here	
	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by California Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Balance & Vestibular Center Physical Therapy may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Balance & Vestibular Center Physical Therapy for services rendered. ➢ I agree that Balance & Vestibular Center Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Balance & Vestibular Center Physical Therapy for services rendered.
	Patient Agreement ➢ I agree to pay Balance & Vestibular Center Physical Therapy charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Balance & Vestibular Center Physical Therapy collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to Balance & Vestibular Center Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Balance & Vestibular Center Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to Balance & Vestibular Center Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Balance & Vestibular Center Physical Therapy may give intermediary's information necessary to process claims.

Patient signature _____ Date

Printed patient name Witness Signature Date

Signature of Legal Representative/POA