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: _____

Dizziness 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		
Sense of rocking/tilting			Ringing in ears		
Sense of floating			Pain/pressure in ears		
Lightheadedness			Headaches		
Dizziness when standing up quickly			Neck pain		
Unsteadiness			Weakness		
Difficulty walking			Fatigue		
Nausea and/or vomiting			Brain fog		
Visual disturbances			Confusion/memory loss		

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

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

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

6. Was the onset of your symptoms: ☐ gradual ☐ sudden ☐ overnight ☐ other (describe)? _____

7. How long do your symptoms last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Weeks

8. Do you have a history of previous symptoms? ☐ Yes ☐ No Approximate year/date symptoms first began? _____

9. If your symptoms are episodic:
   Do you feel free of symptoms between episodes? ☐ Yes ☐ No
   The episodes occur every: ____ hours ____ days ____ weeks ____ months ____ years
   How long does an episode last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Weeks

10. What makes your symptoms worse? (Check all that apply)

√	Activity/Situation	√	Activity/Situation
	Moving my head quickly		Walking
	Riding or driving in the car		Time of day
	Loud sounds or bright lights		Stress
	Large crowds or busy environments		Physical activity/exercise
	Changing positions – bending over, rolling in bed, getting in/out of bed		Eating certain foods
	Menstruation (if applicable)		Coughing, blowing the nose, straining
	Medication		
	Other (describe):		

11. 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: _____

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					

Do you have a history of motion sickness? ☐ Yes ☐ No

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, please indicate how much: _____
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. What activities do you not do anymore because of your problem?
   List activities: _____
9. Are you currently receiving or seeking disability for your condition? ☐ Yes ☐ No
10. What are your goals for physical therapy? _____

"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 _____

Hôpital juif de réadaptation
Jewish Rehabilitation Hospital

Visual Vertigo Analogue Scale

(Adapted from Longridge et al., 2002)

Indicate the amount of dizziness you experience in the following situations by marking off the scales below.

Write a NUMBER from 0 to 10 that best represents your symptoms in each situation.

0 represents no dizziness  and 10 represents the most dizziness 

Walking through a supermarket aisle

 0 ——— 10 

Being a passenger in a car

 0 ——— 10 

Being under fluorescent lights

 0 ——— 10 

Watching traffic at a busy intersection

 0 ——— 10 

Walking through a shopping mall

 0 ——— 10 

Going down an escalator

 0 ——— 10 

Watching a movie at the movie theatre

 0 ——— 10 

Walking over a patterned floor

 0 ——— 10 

Watching action television

 0 ——— 10 

from: J. Vestib Res. 2011;21(3):153-9.

DIZZINESS HANDICAP INVENTORY

Name: _____ **Date:** _____

Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1. Does looking up increase your problem?	Yes	No	Sometimes
E2. Because of your problem, do you feel frustrated?	Yes	No	Sometimes
F3. Because of your problem, do you restrict your travel for business or recreation?	Yes	No	Sometimes
P4. Does walking down the aisle of a supermarket increase your problem?	Yes	No	Sometimes
F5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	No	Sometimes
F6. Does your problem significantly restrict your participation in social activities such As going out to dinner, going to the movies, dancing, or to parties?	Yes	No	Sometimes
F7. Because of your problem, do you have difficulty reading?	Yes	No	Sometimes
P8. Does performing more ambitious activities like sports, dancing, household chores Such as sweeping or putting away dishes increase your problem?	Yes	No	Sometimes
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes	No	Sometimes
E10. Because of your problem, have you been embarrassed in front of others	Yes	No	Sometimes
P11. Do quick movements of your head increase your problem?	Yes	No	Sometimes
F12. Because of your problem, do you avoid heights?	Yes	No	Sometimes
P13. Does turning over in bed increase your problem?	Yes	No	Sometimes
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	No	Sometimes
E15. Because of your problem, are you afraid people might think you are intoxicated?	Yes	No	Sometimes
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	No	Sometimes
P17. Does walking down a sidewalk increase your problem?	Yes	No	Sometimes
E18. Because of your problem, is it difficult for you to concentrate?	Yes	No	Sometimes

F19. Because of your problem, is it difficult for you walk around the house in the dark?	Yes	No	Sometimes
E20. Because of your problem, are you afraid to stay home alone?	Yes	No	Sometimes
E21. Because of your problem, do you feel handicapped?	Yes	No	Sometimes
E22. Has your problem placed stress on your relationships with members of your family or friends?	Yes	No	Sometimes
E23. Because of your problem, are you depressed?	Yes	No	Sometimes
F24. Does your problem interfere with your job or household responsibilities?	Yes	No	Sometimes
P25. Does bending over increase your problem?	Yes	No	Sometimes

---

Part II
Instructions: Put a check in the box that best describes you.

☐	**Negligible symptoms (0)**
☐	**Bothersome symptoms (1)**
☐	**Performs usual work duties but symptoms interfere with outside activities (2)**
☐	**Symptoms disrupt performance of both usual work duties and outside activities (3)**
☐	**Currently on medical leave or had to change jobs because of symptoms (4)**
☐	**Unable to work for over one year or established permanent disability with compensation payments (5)**

STOP HERE

	Yes		**Sometimes**		**No**	
P(7)	_____x4=____	+	_____x2=_____	+	_____x0=____	**Physical Items**_____ **(28)**
E(9)	_____x4=____	+	_____x2=_____	+	_____x0=____	**Emotional Items**_____ **(36)**
F(9)	_____x4=____	+	_____x2=_____	+	_____x0=____	**Functional Items**_____ **(36)**

TOTAL_____
(max 100 pts)