

# 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: \_\_\_\_\_

Patient Registration



## 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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  NoIf 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? <input type="checkbox"/> Yes <input type="checkbox"/> No

**SOCIAL HISTORY AND HABITS**1. Occupation: (if applicable) \_\_\_\_\_  full-time  part-time  unemployed  disabled  retired2. Living situation:  live alone  live with family  live with caregiver  live in assisted living3. 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

	<p><u>Authorization for Treatment</u></p> <ul style="list-style-type: none"> <li>➤ 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.</li> </ul>
	<p><u>Authorization for Release of Information</u></p> <ul style="list-style-type: none"> <li>➤ I agree that Balance &amp; Vestibular Center Physical Therapy may provide information from my medical record to persons involved in my medical care.</li> <li>➤ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Balance &amp; Vestibular Center Physical Therapy for services rendered.</li> <li>➤ I agree that Balance &amp; 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.</li> <li>➤ I have read "Notice of Privacy Practices" mandated by HIPAA.</li> </ul>
	<p><u>Authorization for Release of Payment</u></p> <ul style="list-style-type: none"> <li>➤ I authorize that direct payment of any benefits available to me be released to Balance &amp; Vestibular Center Physical Therapy for services rendered.</li> </ul>
	<p><u>Patient Agreement</u></p> <ul style="list-style-type: none"> <li>➤ I agree to pay Balance &amp; Vestibular Center Physical Therapy charges for services rendered to me during my course of treatment.</li> <li>➤ 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 &amp; Vestibular Center Physical Therapy collections costs including attorney and court fees.</li> </ul>
	<p><u>Medicare, Medicaid, and Similar Benefits</u></p> <ul style="list-style-type: none"> <li>➤ I agree that the information given to Balance &amp; 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 &amp; Vestibular Center Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.</li> </ul>
	<p><u>Workers Compensation</u></p> <ul style="list-style-type: none"> <li>➤ I agree that the information given to Balance &amp; Vestibular Center Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Balance &amp; Vestibular Center Physical Therapy may give intermediary's information necessary to process claims.</li> </ul>

\_\_\_\_\_  
Patient signature Date

\_\_\_\_\_  
Printed patient name Witness Signature Date



\_\_\_\_\_  
 Signature of Legal Representative/POA

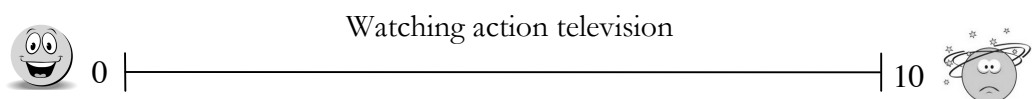
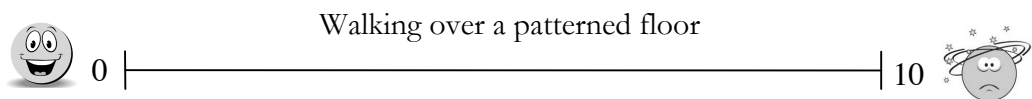
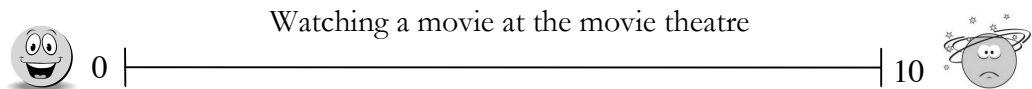
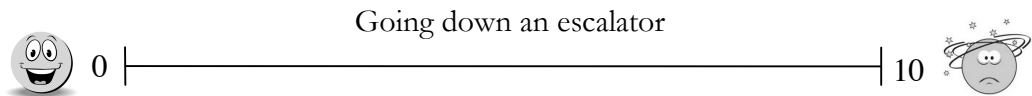
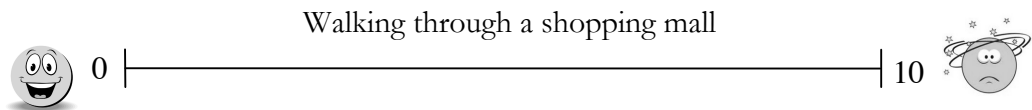
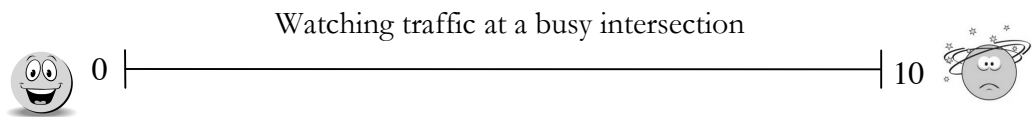
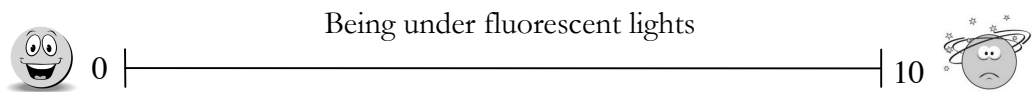
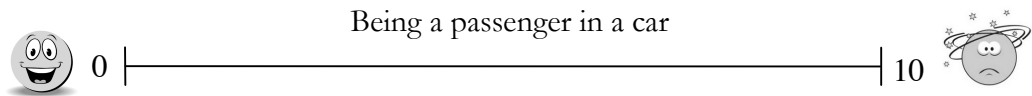
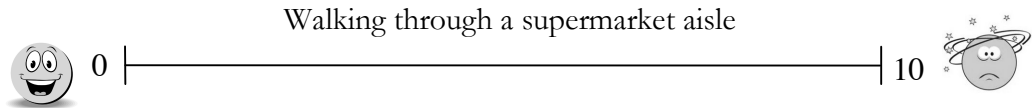
# Visual Vertigo Analogue Scale

(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 



# 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.

<input type="checkbox"/>	Negligible symptoms (0)
<input type="checkbox"/>	Bothersome symptoms (1)
<input type="checkbox"/>	Performs usual work duties but symptoms interfere with outside activities (2)
<input type="checkbox"/>	Symptoms disrupt performance of both usual work duties and outside activities (3)
<input type="checkbox"/>	Currently on medical leave or had to change jobs because of symptoms (4)
<input type="checkbox"/>	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= _____	<b>Physical Items</b> _____ (28)
E(9) _____ x4= _____	+ _____ x2= _____	+ _____ x0= _____	<b>Emotional Items</b> _____ (36)
F(9) _____ x4= _____	+ _____ x2= _____	+ _____ x0= _____	<b>Functional Items</b> _____ (36)
			<b>TOTAL</b> _____ (max 100 pts)