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: _____

BVC
BALANCE & VESTIBULAR CENTER
PHYSICAL THERAPY

VESTIBULAR QUESTIONNAIRE / HEALTH HISTORY

NAME: _____ **DATE:** _____

To insure you receive a complete and thorough evaluation. please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

1. Reason for Referral _____

_____

2. Which of the following best describes your symptoms? (check all that apply)

- ❒ (1) imbalance
- ❒ (2) trouble walking
- ❒ (3) staggering
- ❒ (4) sense of leaning/tilt
- ❒ (5) undulations (as if on a boat)
- ❒ (6) vertigo (spinning events)
- ❒ (7) sense of floating
- ❒ (8) nausea/queasiness
- ❒ (9) visual confusion
- ❒ (10) blurry vision
- ❒ (11) jumping vision
- ❒ (12) pain in ears
- ❒ (13) ringing in ears
- ❒ (14) hearing loss
- ❒ (15) headache
- ❒ (16) pain in neck
- ❒ (17) lightheadedness
- ❒ (18) disorientation
- ❒ (19) poor concentration, memory or attention
- ❒ (20) fatigue
- ❒ (21) weakness (location) _____
- ❒ (22) other_____

3. When did you first notice this episode of symptoms (Please indicate a specific date if possible)? _____

4. Was the onset of this episode gradual or sudden? (Check one) ❒ (1) gradual ❒ (2) sudden

5. Which of the following best describes the reason for your symptoms?

- ❒ (1) a MVA (auto accident)
- ❒ (2) a fall
- ❒ (3) trauma
- ❒ (4) during recreation/sports
- ❒ (5) an infection
- ❒ (6) after taking drugs/antibiotics
- ❒ (7) aging
- ❒ (8) unknown
- ❒ (9) other_____

6. Since onset are your symptoms getting

❒ (1) better ❒ (2) worse ❒ (3) not changing

7. Are your symptoms:

- ❒ (1) constant
- ❒ (2) provoked by head movement or activity
- ❒ (3) spontaneous

8. Have you ever fallen?

- ❒ (1) no
- ❒ (2) yes-once in the last week
- ❒ (3) yes-more than once this week
- ❒ (4) other _____

9. What aggravates your symptoms?

- ❒ (1) lying down
- ❒ (2) going to/rising from sitting
- ❒ (3) riding in or driving a car
- ❒ (4) walking
- ❒ (5) visual motion
- ❒ (6) medication
- ❒ (7) other _____ _____

10. Have you ever had vestibular testing?

❒ (1) No ❒ (2) Yes Results:_____

_____

11. Activities you do not do because of your problem:

_____

_____

12. Since the onset of your current symptoms have you had:

- ❒ (1) any difficulty with control of bowel or bladder function
- ❒ (2) fever/Chills
- ❒ (3) any numbness in the genital or anal area
- ❒ (4) numbness
- ❒ (5) any dizziness or fainting attacks
- ❒ (6) weakness
- ❒ (7) unexplained weight change
- ❒ (8) night pain/sweats
- ❒ (9) malaise (vague feeling of bodily discomfort)
- ❒ (10) problems with vision/hearing
- ❒ (11) none of the above

MEDICATION

Please list any **prescription** medications you are currently taking *(pain pills, injections and/or skin patches etc.):*

_____

_____

_____

Are you currently taking any of the following over the counter medications?

- ❒ (1) aspirin
- ❒ (2) Tylenol
- ❒ (3) corticosteroids
- ❒ (4) antihistamines
- ❒ (5) vitamins/mineral supplements
- ❒ (6) Advil/Motrin/ibuprofen
- ❒ (7) other _____

PREVIOUS FUNCTIONAL LEVEL

❒ **Independent in all activities** (work, community, home, recreation)

Self Care

❒ Independent in all self-care (bathing, toileting, dressing, etc.) activities
❒ Have difficulty performing self-care activities
❒ Need assistance with self-care activities
❒ Have difficulty performing household chores

Social

❒ Need assistance with activities in community outside of home

Hobbies:_____

_____

WORK HISTORY

Occupation_____

❒ (1) employed full time
❒ (2) employed part time
❒ (3) self employed
❒ (4) homemaker
❒ (5) student
❒ (6) retired
❒ (7) unemployed
❒ (8) other _____

Physical activities at work

❒ (1) sitting
❒ (2) standing
❒ (3) phone use
❒ (4) repetitive lifting
❒ (5) heavy lifting
❒ (6) computer use
❒ (7) heavy equipment operation
❒ (8) driving
❒ (9) other _____

Are you currently receiving for seeking disability for this condition? ❒ Yes ❒ No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?
❒ Yes ❒ No

LIVING SITUATION

❒ (1) live alone
❒ (2) live with family member/others
❒ (3) live with caregiver
❒ (4) home/apartment
❒ (5) retirement complex (SNF/ ICF)
❒ (6) assisted living complex
❒ (7) other _____

Setting

❒ (1) stairs railing
❒ (2) stairs no railing
❒ (3) no stairs
❒ (4) ramp
❒ (5) elevator
❒ (6) uneven ground

other _____

GENERAL HEALTH

How would you rate your general health?
❒ Excellent ❒ Average ❒ Poor
❒ Good ❒ Fair

Height_____ Weight_____

Do you exercise outside of normal daily activities?
❒ (1) 5+days/wk
❒ (2) 3-4 days/wk
❒ (3) 1-2days/wk
❒ (4) occasionally
❒ (5) zero

Exercise, Sports/Recreation consisting of _____

_____

Do you drink caffeine containing beverages?
❒ No ❒ Yes How many/much per day? _____

Do you smoke?
❒ No ❒ Yes Packs of cigarettes a day? _____

What is your stress level?
❒ Low ❒ Medium ❒ High

Are you seeing any health care providers other than the physical therapist for this current condition?(list)

_____

_____

PAST MEDICAL HISTORY

Have you ever had/ been diagnosed with any of the following conditions?

❒ Cancer (type)_____
❒ Depression
❒ Stroke
❒ Kidney Problems
❒ Thyroid problems
❒ Diabetes
❒ Multiple Sclerosis
❒ Arthritis
❒ Head Injury
❒ Stomach problems
❒ Parkinson's Disease
❒ Circulation/vascular problems
❒ Infectious Diseases (i.e. hepatitis, tuberculosis)
❒ Heart Problems
❒ High blood pressure
❒ Lung Problems
❒ Blood Disorders
❒ Epilepsy/Seizures
❒ Allergies
❒ Rheumatoid arthritis
❒ Osteoporosis
❒ Broken bone
❒ Other _____

Please list any recent/relevant past surgeries related to your current problem:

SURGERY	**DATE**

FAMILY HISTORY

Has anyone in your immediate family *(parents, brothers, sisters)* ever been treated for any of the following?

❒ Diabetes
❒ Heart disease
❒ High blood pressure
❒ Stroke
❒ Cancer
❒ Arthritis
❒ Osteoporosis
❒ Psychological Condition
❒ Other _____

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

"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

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: _____