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	REFERRED BY:
☐ HOME ( ) _____	☐ DOCTOR _____
☐ CELL ( ) _____	☐ FRIEND _____
☐ WORK ( ) _____	☐ OTHER _____

EMAIL

☐ I prefer appointment reminders be sent to my email

MARITAL STATUS

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT INFORMATION

NAME	RELATION TO PATIENT

ADDRESS

CITY STATE ZIP CODE

PHONE ( )	ALTERNATE ( )

WORKERS COMPENSATION / ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO	WERE YOU INJURED ON THE JOB ☐ YES ☐ NO	DATE OF INJURY/ACCIDENT	CLAIM NUMBER

NAME OF INSURANCE CARRIER	PHONE ( )	FAX ( )

CLAIMS ADJUSTER	PHONE ( )	FAX ( )

NURSE CASE MANAGER	PHONE ( )	FAX ( )

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

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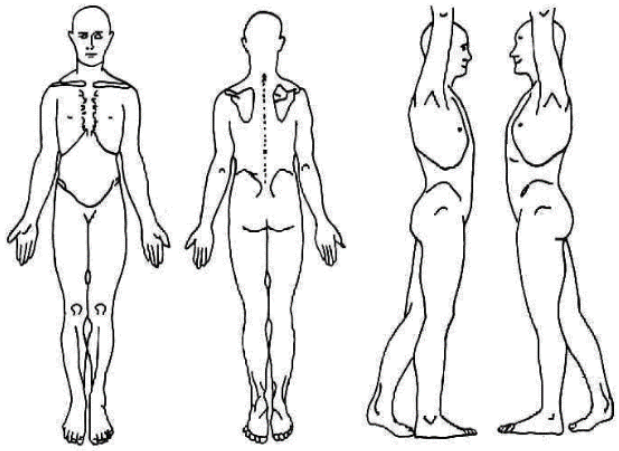
Neurologic Patient History

Name:			Date:	
Date of Birth:	Age:	Height:	Weight:	Next Doctors Visit:
Occupation:			Have you been a patient here before?	

What brings you to physical therapy?	
Current Problem/Symptoms	When did the problem start?
1.	
2.	
How often do you experience you symptoms? (please circle one) *0-25% intermittently* *26-50% occasionally* *51-75% frequently* *76-100% constantly*	
Are your symptoms changing? (please circle one) *improving* *not changing* *getting worse*	

I currently am not experiencing any pain. True ☐ (skip to next page) False ☐ (please fill out below)



What is the nature of your symptoms?
Circle all that apply
Numbness / Tingling Shooting
Burning Throbbing Sharp Dull/Achy
Weakness Constant Intermittent
Worse in AM, PM, at night

What is the intensity level 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

Pain increases during the following activities	
1)	3)
2)	4)

Pain decreases during the following activities	
1)	3)
2)	4)

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Name:	Date:

Please list your goals in coming to physical therapy.

Please indicate if you have had or have any of the following conditions.					
Condition	Yes	No	Condition	Yes	No
History of Cancer			Pacemaker		
Heart disease			Diabetes I or II		
High/Low blood pressure			Allergies/Asthma		
Angina / Chest pain			Memory Loss		
Shortness of breath			Headaches / Migraines		
Stroke / TIA			Hernia		
Osteoporosis			Nausea or vomiting		
Osteoarthritis			Bowel or bladder problems		
Rheumatoid arthritis			HIV - positive / AIDS/Hepatitis		
Joint replacement			Dementia/Alzheimer's Disease		
Recent excessive weight loss			Pregnant (currently)		
Changes in appetite			Seizures		
Lightheadedness/Dizziness			Fainting		
Frequent loss of balance			Difficulty sleeping		
Falls			Smoking tobacco		
Anxiety / Stress			Vision (glasses / contacts)		
Depression			Hard of hearing / hearing aid		
Fibromyalgia			Lupus		
Obesity			Parkinson's/Huntington's		
TBI/History of Concussions			Alcoholism		

Please list any other medical conditions, surgeries, or health concerns not listed above.	
Condition/Surgery	Date
Which diagnostic tests have you had? (please circle all that apply) *X-Ray MRI CT scan VNG Blood Work PET scan EMG EEG Other:*	

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Name:	Date:

Do you have any problems with the following?		
Yes	No	
		Have you fallen?
		If yes, have you had 2 or more falls in the past year?
		If yes, have you had any fall with injury in the past year?
		Difficulty walking (if so, circle all that apply: firm / uneven surfaces (i.e. grass, sand)
		Problems climbing stairs ❑ I must use a rail ❑ I can go up/down stairs without a rail
		Difficulty standing still
		Rising from a chair without using your hands
		Can you get up off the floor by yourself?
		Clumsiness of arms or legs
		Weakness of arms or legs
		Difficulty with speech
		Difficulty with swallowing
		Problems with memory
		Impaired vision
		Double or Blurred vision
		Objects move up and down / side to side when walking or running
		Flashes of light
		Trouble reading
		Have you had previous problems with your ears?
		Difficulty hearing
		Ear pain
		Drainage from ears
		Does your hearing fluctuate or worsen with dizzy episodes?
		Ringing in the ears or head noise (if so, which ear? ❑ Right ❑ Left)
		Fullness or pressure in the ears (if so, which ear? ❑ Right ❑ Left)
		Facial weakness or numbness

List all doctors you would like to receive a copy of your physical therapy evaluation.		
MD Name	Address/Phone/Fax	Specialty
Referring MD		
Primary Care MD		
Other MD		

I certify that the foregoing statements are true to the best of my knowledge and belief.	
Signature of Patient	Date
Reviewed by Physical Therapist	Date

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Medication List

Patient Name: _____ Date: _____

Please list your current medications (including over-the-counter, vitamins, herbal, and dietary supplements).

❑ See attached list

Name	Dosage	Frequency	Administration Route (ex: oral, injection, etc.)	What condition is this for?

Date	Modifications	No Changes	Reviewing Physical Therapist

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Falls Efficacy Scale

Patient Name: _____ Date: _____

Instructions: On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Activities	Very Confident									Not Confident at All
1. Take a bath or shower	1	2	3	4	5	6	7	8	9	10
2. Reach into cabinets or closets	1	2	3	4	5	6	7	8	9	10
3. Walk around the house	1	2	3	4	5	6	7	8	9	10
4. Prepare meals not requiring heavy or hot objects	1	2	3	4	5	6	7	8	9	10
5. Get in and out of bed	1	2	3	4	5	6	7	8	9	10
6. Answer the door or telephone	1	2	3	4	5	6	7	8	9	10
7. Get in and out of a chair	1	2	3	4	5	6	7	8	9	10
8. Getting dressed and undressed	1	2	3	4	5	6	7	8	9	10
9. Personal grooming (i.e. washing your face)	1	2	3	4	5	6	7	8	9	10
10. Getting on and off of the toilet	1	2	3	4	5	6	7	8	9	10

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Activities-Specific Balance Confidence Scale

Patient Name: _____ Date: _____

Instructions: For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

(not confident) **0 10 20 30 40 50 60 70 80 90 100** (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 tiptoes 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 an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding parcels that you cannot hold onto the railing? _____%
16. …walk outside on icy sidewalks? _____%