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 ☐ HOME ( ) ____________________ ☐ CELL ( ) ____________________ ☐ WORK ( ) ____________________	REFERRED BY: ☐ DOCTOR ____________________ ☐ FRIEND ____________________ ☐ 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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FACIAL NERVE PARALYSIS PATIENT INTAKE QUESTIONNAIRE

Patient Name: ________________________________ **Age**: ________ **Date**: _____/_____/_____

Diagnosis or Cause of Facial Paralysis: □ Bell's palsy □ Acoustic Neuroma □ Ramsay Hunt □ Trauma □ Other

Side of Involvement: □ Right □ Left □ Both **Onset / Surgery**: _____________

Occupation / Hobbies: ____

Initial Involvement:

- ❑ Onset was: O sudden O gradual
- ❑ I lost: O all movement O partial movement

Recovery Process:

- ❑ I began to see movement return __________ O weeks / O months later

Relevant Past Medical History (check all that apply):

Special Tests	Previous Treatment
❑ MRI / MRA	❑ initially had antivirals / steroids
❑ Blood tests	❑ physical therapy
❑ CT scan	❑ electrical stimulation
❑ Evoked electromyography (EMG)	❑ acupuncture
❑ Hearing test	❑ psychologist
	❑ psychiatrist
	❑ Botox Date of last Botox injection: ________
	❑ Plastic surgery

Functional Complaints (check all that apply):

❑ Pain/tightness (if so, where?)	
❑ Dry eyes	❑ Dizziness
❑ Excessive tearing	❑ Imbalance
❑ Difficulty eating/drinking	❑ Depressed
❑ Difficulty with speech/communication	❑ Altered feeling/sensation
❑ Headaches	❑ Altered taste
❑ Headaches	❑ Hearing loss
❑ Difficulty performing job/hobbies	❑ Avoiding social settings

Please list your goals:

1. ____
2. ____
3. ____
4. ____

How much caffeine (coffee, soda, iced tea, chocolate) **do you consume per day**? ________________________

Do you smoke? □ NO □ YES **Do you consume alcohol?** □ NO □ YES

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Please list all SURGERIES and dates: *(continue on back of page if necessary)*

Surgery	Date

Please list all SERIOUS ILLNESSES and dates: *(continue on back of page if necessary)*

Illness	Date

List your *CURRENT MEDICATIONS* (including over the counter, vitamins and herbs): ☐ **See attached list**

Medication/Vitamin/Herb	Dose	Frequency	Administration Route (for example: by mouth, injection, etc.)

PHYSICIAN INFORMATION: *List **all** doctors you would like to receive a copy of your physical therapy evaluation.*

Neurologist/ENT/Cardiologist/Gerontologist/Osteopath	Address/Phone/Fax	Specialty
Referring MD:		
Primary Care MD:		
Others MDs:		

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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FACIAL DISABILITY INDEX

Patient Name: ____ Date: ________________

Please circle the most appropriate response to the following questions related to problems with the function of your facial muscles. For each question, consider your function **during the past month**.

1. How much difficulty did you have keeping food in your mouth, moving food around in your mouth, or getting food stuck in your cheek while eating?

Usually did with:	Usually did not eat because:
5 - no difficulty	1 - of health
4 - a little difficulty	0 - of other reasons
3 - some difficulty	
2 - much difficulty	

2. How much difficulty do you have drinking from a cup?

Usually did with:	Usually did not eat because:
5 - no difficulty	1 - of health
4 - a little difficulty	0 - of other reasons
3 - some difficulty	
2 - much difficulty	

3. How much difficulty did you have saying specific sounds while speaking?

Usually did with:	Usually did not drink because:
5 - no difficulty	1 - of health
4 - a little difficulty	0 - of other reasons
3 - some difficulty	
2 - much difficulty	

4. How much difficulty did you have with your eye tearing excessively or becoming dry?

Usually did with:	Usually did not speak because:
5 - no difficulty	1 - of health
4 - a little difficulty	0 - of other reasons
3 - some difficulty	
2 - much difficulty	

5. How much difficulty did you have with brushing your teeth or rinsing your mouth?

Usually did with:	Usually did not tearing because:
5 - no difficulty	1 - of health
4 - a little difficulty	0 - of other reasons
3 - some difficulty	
2 - much difficulty	

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6. How much of the time have you felt calm and peaceful?

6 - all of the time	5 - most of the time
4 - a good bit of the time	3 - some of the time
2 - a little of the time	1 - none of the time

7. How much of the time did you isolate yourself from people around you?

1 - all of the time	2 - most of the time
3 - a good bit of the time	4 - some of the time
5 - a little of the time	6 - none of the time

8. How much of the time have did you get irritable toward those around you?

1 - all of the time	2 - most of the time
3 - a good bit of the time	4 - some of the time
5 - a little of the time	6 - none of the time

9. How often did you wake up early or wake up several times during your nighttime sleep?

1 - every night	2 - most nights
3 - a good number of nights	4 - some nights
5 - a few nights	6 - no nights

10. How often has your facial function kept you from going out to eat shop or participate in family or social events?

1 - all of the time	2 - most of the time
3 - a good bit of the time	4 - some of the time
5 - a little of the time	6 - none of the time

Scoring: Physical Function: $\frac{\text{Total Score (questions 1-5)} - N}{N} \times \frac{100}{4}$ Social Function: $\frac{\text{Total Score (questions 6-10)} - N}{N} \times \frac{100}{5}$

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SYNKINESIS ASSESSMENT QUESTIONNAIRE (SAQ)

Patient Name: ______________________________________ Date: ____________________

Instructions: Please answer the following questions regarding facial function, on a scale from 1-5, according to the following scale:

1 = seldom or not at all

2 = occasionally, or very mildly

3 = sometimes, or mildly

4 = most of the time, or moderately

5 = all the time, or severely

	Question	Score (1-5)
1.	When I smile, my eye closes	
2.	When I speak, my eye closes	
3.	When I whistle or pucker my lips, my eye closes	
4.	When I smile, my neck tightens	
5.	When I close my eyes, my face gets tight	
6.	When I close my eyes, the corner of my mouth moves	
7.	When I close my eyes, my neck tightens	
8.	When I eat, my eye waters	
9.	When I move my face, my chin develops a dimpled area	
	Office use only Sum of Scores 1-9	
	Office use only SAQ Total Score	

Summate scores for questions 1-9 /45 x 100 = SAQ Total Score