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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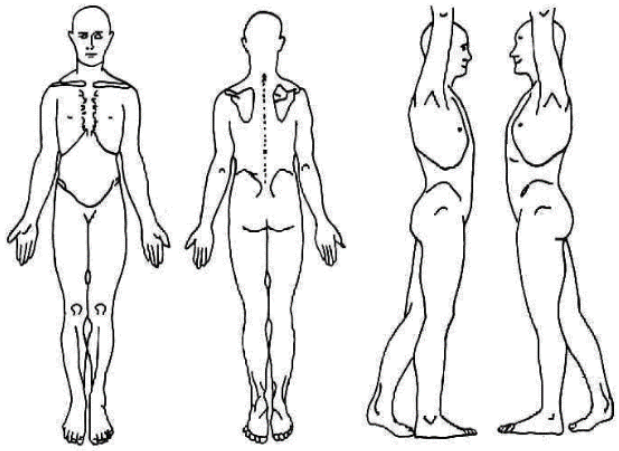
Orthopedic Patient History

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?
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		

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Name:	Date:

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:*	

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?

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).

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

Date	Modifications	No Changes	Reviewing Physical Therapist