FYZICAL®
Therapy & Balance Centers

HEALTH HISTORY AND WELLNESS SCREEN

NAME: ____ DATE: ______________________

Please indicate whether you currently have or previously had of any of the following conditions:

Alzheimer’s Disease	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	Current Infection	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No	Dizzy Spells	☐ Yes ☐ No
Cardiac pacemaker	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Diabetes Type I	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Diabetes Type 2	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Smoking	☐ Yes ☐ No
Fracture/Broken bone	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No	Speech problems	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Depression	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Concussion	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Immunosuppression	☐ Yes ☐ No	Ringing in ears	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	Parkinson’s Disease	☐ Yes ☐ No	Hearing loss	☐ Yes ☐ No

Any other health issue not listed: ____

Current Problem:

What brings you to FYZICAL today? ____

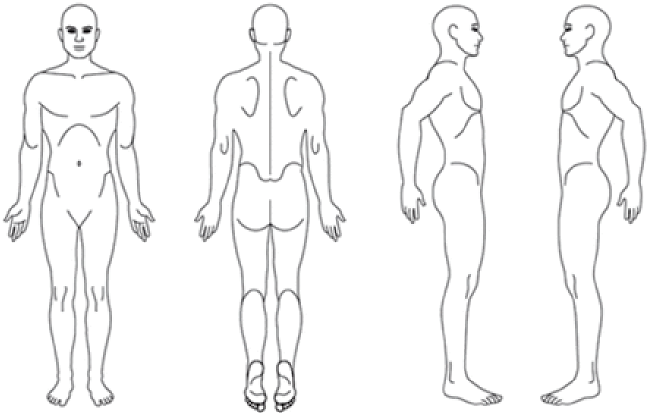
____

Have you had any special tests related to your condition? (CT scan, X-Ray, MRI) ____________________________

____

What activities/positions make your condition worse? ____

What activities/positions make your condition better? ____



Please indicate on the drawing any areas that you are having pain.

Work/Activity History:

Has this condition resulted in an absence from work and/or modified duty OR a change in the way you perform your usual daily activities? ____

____

What are the most difficult tasks for you to perform on your job OR during your normal day to day activities due to your current problem? ____

____

What type of exercise/sport do you perform on a regular basis? ____

____

Are you still able to perform these activities with your current problem? ________________________________

What are your goals for therapy? ____

____

Please answer the following questions about your general health and well-being:

1. Have you had a fall in the past year?	☐ Yes	☐ No
2. Do you have a fear of falling?	☐ Yes	☐ No
3. Would you like your balance to be assessed?	☐ Yes	☐ No
4. Do you experience imbalance?	☐ Yes	☐ No
5. Do you lose your balance when stepping up/down curbs or on stairs?	☐ Yes	☐ No
6. Do you have a difficult time walking in the dark?	☐ Yes	☐ No
7. Do you get episodes of vertigo where the room actually spins?	☐ Yes	☐ No
8. Do you have neck or back pain?	☐ Yes	☐ No
9. Do you sleep with more than one pillow under your head?	☐ Yes	☐ No
10. Do you have foot and/or ankle pain or discomfort?	☐ Yes	☐ No
11. Do you currently wear shoe inserts (orthotics)?	☐ Yes	☐ No
12. Are you interested in learning about how a shoe insert could decrease pain and help your condition?	☐ Yes	☐ No
13. Do you have pain and/or physical challenges other than what you are being seen for today?	☐ Yes	☐ No
14. Are you interested in learning how a medically based fitness program could safely improve your well-being and overall health?	☐ Yes	☐ No

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Name: ____ **Date:** _____________________

MEDICATION LIST

Are you taking any medications? ☐ **No** ☐ **Yes** – see instructions below

If you have a written list of your medications, we will scan it into your records and this page does not need to be filled out. If you do not have a list, please fill out your current medications.

Drug: ___________________________________ Dosage: _________ Frequency_________Reason Taking _______________________

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Drug: ___________________________________ Dosage: _________ Frequency_________Reason Taking _______________________

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FINANCIAL AND TREATMENT AUTHORIZATION

Insurance: I authorize FYZICAL to bill my insurance company for my physical therapy visits. I assign all payments from my insurance company to be made directly to FYZICAL. I acknowledge that I am wholly responsible for full payment to FYZICAL for all physical therapy services rendered including all applicable co-payments and any amounts not paid by insurance. In the event that FYZICAL has entered into an agreement with my insurance company to reduce their rates, FYZICAL will not bill me any PPO agreed upon reductions. I agree to make down-payments toward any applicable co-payments and deductibles at each visit as determined by the "Benefit Clarity" document provided by FYZICAL. Once my insurance company has paid, PPO reductions have been applied and all my down-payments are applied, I acknowledge a balance may exist that I am wholly responsible for and will pay upon receipt of a written statement.

Self-pay: In the case of Medicaid, no insurance coverage, no out of network benefits, or no authorization/approval for treatment a flat fee will be determined for services rendered. This flat fee will be payable at the time the service is rendered.

Work, Personal, or Auto Injury: In the case of a work, personal, or auto injury, I will also provide my health insurance information. In the event that claims are denied by the liability carrier, I authorize FYZICAL to bill my health insurance. I acknowledge that I am fully responsible for payment of all claims in the event my health insurance and liability carrier deny my claims.

Appointments: Physical Therapy treatments are by appointment only on a first come, first serve basis. **I understand there is a $35 fee for cancellation without 24 hours' notice or failure to show for a scheduled appointment.** The $35 fee will be waived if the appointment is rescheduled within the same week.

Please indicate how would you like reminders for your appointments:

____Phone Call ______Text Message _____Email _____Do Not Confirm

Do we have permission to leave a message on your voice mail? ☐ Yes ☐ No

Treatment: I authorize my physician to release to FYZICAL any medical or other information necessary for my Physical Therapist to fully understand my condition and make a treatment plan. I authorize FYZICAL to release information to my physician regarding my treatment plan and progress during physical therapy.

Privacy Policy: I acknowledge that I have been shown a copy of FYZICAL's privacy policies and: (please initial one choice)

______ I **do not** want a copy of the privacy policy

______ I want a copy of the privacy policy

May we send you occasional emails regarding seminars or other informational activities for FYZICAL? (no more than 2X a month and we never share emails with third parties) ☐ Yes ☐ No

Do you wish to give permission for your therapist to discuss your condition with another person?

☐ Yes ☐ No If yes, who? ____ Relation ______________________________

Patient Signature: ____ **Date:** ____________________________

Printed Name: ____