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: ____

<u>Current Problem:</u>

What brings you to FYZICAL today? ____

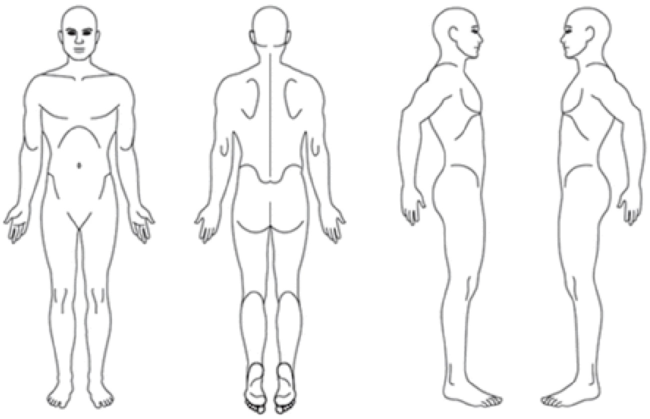
____

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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Drug: __________________________________ Dosage: _________ Frequency_________Reason Taking ______________________

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 certify that the insurance provided to FYZICAL is current and correct. 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 services rendered including all 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. If the insurance card is later found to be outdated or invalid, or for whatever reason my insurance carrier declines to pay for any medical services I received through FYZICAL, I understand I am responsible for paying for the services in full.

INITIAL______________

Billing: I agree to make down-payments toward any applicable co-payments, coinsurances and deductibles at each visit as determined by the "Benefit Estimate" document provided by FYZICAL. Once my insurance company has paid, PPO reductions and all my down-payments are applied, I acknowledge a balance may exist which I am wholly responsible for and will pay within 30 days of receipt of a written statement. I acknowledge that failure to honor this agreement will result in my account being sent to collections. I agree to pay any and all associated costs (banking, legal and collections fees) for an unpaid balance over 90 days.

INITIAL______________

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.

INITIAL______________

Consent to Treat: I hereby consent to receive care for therapy serviced by Fyzical Therapy and Balance Centers. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

INITIAL______________

Cancellation Policy: Physical Therapy treatments are by appointment only on a first come, first served basis. I understand there is a $35 fee for cancellation less than 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.

INITIAL______________

Returned Check Fee: I understand and agree to pay a $50 service charge to FYZICAL for any checks returned for insufficient funds.

INITIAL______________

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. INITIAL______________

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

______Yes ______No If yes, who:____ Relation:_______________________

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

Patient Signature:____ **Date:**_____________________

Printed Name:____