FYZICAL
Therapy & Balance Centers

Client Information

Last Name: _____First Name: _____Middle Initial:_____

Address:_____

City:_____State: _____ Zip:_____

Date of Birth:_____Sex:_____Social Security #_____

Home Phone #:_____Work Phone #:_____Cell #:_____

Email:_____ Marital Status: (circle one) Single Married Divorced Widowed

Emergency Contact: _____Phone #_____Relationship_____

Primary Care Physician / Family Doctor(s)_____

Have you had any Home Health in the past 12 months?____No____Yes, name of Co._____

Have you had any physical, occupational, or speech therapy this year? ☐ Yes ☐ No

How did you hear about FYZICAL®?_____

If Client is a minor

Responsible party for bill if other than client:_____Relationship:_____

Responsible party's address (if other than above):_____

Date of Birth:_____ Social Security #_____

Consent for Treatment:
I hereby consent to receive care for therapy services by FYZICAL®. I consent to medical treatment as is deemed necessary or advisable by the physical or occupational therapist.

Consent to Release Medical Information:
I authorize FYZICAL® to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____

Consent to Obtain Medical Information:
I authorize FYZICAL® to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

Assignment of Insurance Benefits:
I hereby authorize payment to be made directly to FYZICAL®.

Guarantee of Payment:
I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I hereby certify that I understand these rights as set forth.

I acknowledge that I have been informed of FYZICAL®'s Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA) I have been presented with a brochure outlining these practices ☐ Yes ☐ No

I have received a copy of the Summary of the Florida Client's Bill of Rights and Responsibilities ☐ Yes ☐ No

Client/Responsible Party Signature_____Date:_____

Legal Representation (if applicable): Attorney's Name _____

CLIENT HEALTH QUESTIONNAIRE

FYZICAL® Therapy & Balance Centers

Name _____ Age _____ Date _____/_____/_____

Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

Please tell us when your condition started: _____

List tests or other interventions for this condition that you have had: _____

Please indicate the daily activities that you cannot perform: _____

Please indicate your level of functioning prior to the onset of this condition: _____

Please inform us of any environmental or living conditions that may have difficulties with: _____

Did you have surgery? ☐ No ☐ Yes Date ____/____/____ Procedure: _____

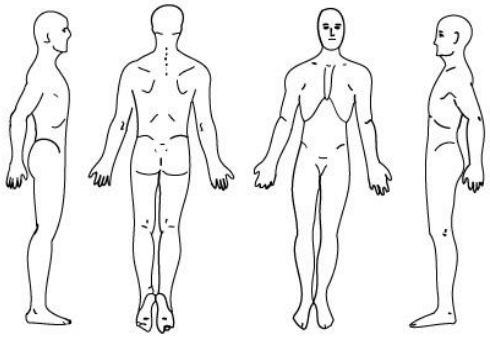
Please describe the nature of your pain:

- ☐ Sharp Pain
- ☐ Dull (Pain) Ache
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

.

- ☐ Constant (76 – 100%)
- ☐ Frequent (51 – 75%)
- ☐ Occasional (26 – 50%)
- ☐ Intermittent (25% - or less)

MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS ➔➔➔➔



Indicate the intensity of your pain at rest: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your pain with movement: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Your symptoms are worse in: ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Occupation _____ Has your work status changed because of this condition ☐ YES ☐ NO

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	HIV/AIDS (042)
☐	☐	Cancer (199.1) Location: _____Date: _____
☐	☐	Tumor (229.9)
☐	☐	Systemic Lupus (710.0)
☐	☐	Hepatitis (5
☐	☐	Epilepsy (349.5)
☐	☐	Diabetes (250.0)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Arthritis (716.9)
☐	☐	Pregnancy
☐	☐	Other _____
☐	☐	Tobacco (305.1) packs/day _____
☐	☐	Drug or Alcohol Dependence (303.9)

Hospitalization/Surgical Procedures (list if not described elsewhere):

_____

_____

_____

Do you have a Pace Maker: _____yes _____no

Medications:

_____

_____

_____

Present: Weight _____ Height _____ft _____in.