



VESTIBULAR PATIENT REGISTRATION FORM

NAME _____ BIRTHDATE _____

ADDRESS _____

CONTACT PHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

E-MAIL ADDRESS _____ OCCUPATION _____

EMERGENCY CONTACT NAME _____ EMERGENCY CONTACT PHONE NUMBER _____

Marital Status: Married Single Widow/Widower Divorced

Is your condition a result of (Please Check One):

Work Related Injury Auto Accident

WHAT IS THE NATURE OF YOUR INJURY _____

When was the date of Injury/Accident/Other: _____

On the following scale of 0 – 10, how would you rate your dizziness?



Dizziness is: Constant Intermittent

Do you have other symptoms?

- Swelling Stiffness Weakness
- Tenderness Tightness Limited Motion
- Numbness Tingling Sensation Headaches
- Fever/Chills/Sweats Bowel/Bladder Changes

Others _____

Due to your condition do you have difficulty:

- | | |
|--|---|
| <input type="checkbox"/> walking | <input type="checkbox"/> balancing |
| <input type="checkbox"/> sleeping | <input type="checkbox"/> getting up from bed/chair |
| <input type="checkbox"/> performing work duties | <input type="checkbox"/> performing light domestic duties |
| <input type="checkbox"/> performing heavy domestic duties | <input type="checkbox"/> performing your recreation/ sport activities |
| <input type="checkbox"/> personal care activities
(dressing, washing, etc.) | <input type="checkbox"/> commuting/ traveling |
| <input type="checkbox"/> driving | <input type="checkbox"/> changing positions |

Have you fallen recently: Yes No

LEISURE ACTIVITIES OR HOBBIES

WHAT ARE YOUR GOALS?

HOW DID YOU HEAR ABOUT BE FIT PHYSICAL THERAPY?

Please list any PRESCRIPTION medication you are currently taking: (pills, injections, and/or skin patches)

Please check the following OVER-THE-Counter medication you have taken in the last week.

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Motrin | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Decongestants | <input type="checkbox"/> Vitamin |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Antihistamines |
| <input type="checkbox"/> Others _____ | | |

Please check any of the following medical professional you are currently seeing:

- | | | | |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Osteopath | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Dentist | <input type="checkbox"/> Nurse Practitioner | |

REFERRING PHYSICIAN

OTHER PHYSICIANS

If you have been seen by any of the above during the last three months, please describe for what reason (illness, medical condition, physical examination, ect.)

Please check any of the following condition that you have EVER been diagnosed with and Describe below

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Other Arthritic Conditions | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other |

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Please describe any injures for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Have you had any testing for your dizziness? (MRI, VNG, CT Scan, etc.): Yes No

Have you currently experienced:

- Yes No Weight loss/ Gain
- Yes No Nausea/ Vomiting
- Yes No Fatigue
- Yes No Weakness
- Yes No Fever/ Chills/ Sweats
- Yes No Numbness or Tingling
- Yes No Do you have any pain?

Is there anything else you would like for us to know?

CONSENT FOR TREATMENT & RELEASE OF INFORMATION

Insurance Authorization and Assignment of Benefits

I Authorize Be Fit Physical Therapy & Pilates, LTD to deposit checks received on my account when made out to me. I understand if the insurance company sends payment directly to me, I am responsible for returning payment over to Be Fit Physical Therapy & Pilates, LTD upon receipt of the check. Failure to do so will result in me being responsible for the total balance due on the account in full. I understand that I AM RESPONSIBLE for any and all charges, costs, and fees incurred during my evaluation and treatment program at Be Fit Physical Therapy & Pilates, LTD., not covered by my insurance carrier (S). In the case of no insurance coverage, I am responsible for payment in full. If I am unable to pay the balance until paid in full, It is my responsibility to make financial arrangements and make regular payments on my account balance until paid in full. Further, I understand that all delinquent accounts are turned over for collection to a third party agency if no payment is received for 75 days. This agency does report to all credit bureaus for recording on personal credit history. If I fail to pay for these services, I agree to pay the collection agency fees, attorney fees, and court costs incurred in collecting the dept. I consent to the above billing procedures as confirmed by my signature below.

I, or my (child) has a condition, which a licensed physician has prescribed physical therapy as part of my treatment plan. I request and consent to Be Fit Physical Therapy & Pilates, LTD and its physical therapist, assistants, and professional staff, to perform therapeutic procedures that may be necessary for my rehabilitative treatment as necessary and desirable in the exercise of professional judgment. It is not possible to make guarantees concerning the results of this or any treatment. I acknowledge that no such guarantees have been made to me. I also authorize Be Fit Physical Therapy & Pilates, LTD to obtain and release any medical information, verbal or written, necessary to provide appropriate patient care. I understand that all information exchanged is maintained under the Be Fit Physical Therapy & Pilates, LTD confidentially policy.

Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to an emergency. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

If your appointment is not cancelled at least 24 hours in advance, you will be charged a \$50.00 fee; this will not be covered by your insurance company. **Patient Initials:** _____

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL.

I give my consent and authorization for the Medical or Billing Staff of Be Fit Physical Therapy & Pilates, LTD., to leave protected health care information about me or for me on any answering machine or voice mail via the telephone at the number I have listed below. I understand I revoke this privilege at any time by submitting my request in writing to retrieve results of all test and procedures.

SIGNATURE

PHONE NUMBER

DATE

RESTRICTIONS (S)

Pursuant to Health insurance portability and Accountability Act of 1996, I acknowledge that I have received a copy of the Notice of Privacy Practice. Initial: _____ Date: _____

Dizziness Handicap Inventory

Date of Birth _____ Today's Date _____

Name _____ Height _____ ft. _____ in. Weight _____ lbs.

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "always", or "no" or "sometimes" to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	No
P1	Does looking up increase your problem?			
E2	Because of your problem, do you feel frustrated?			
F3	Because of your problem, do you restrict your travel for business or pleasure?			
P4	Does walking down the aisle of a supermarket increase your problem?			
F5	Because of your problem, do you have difficulty getting into or out of bed?			
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?			
F7	Because of your problem, do you have difficulty reading?			
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?			
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?			
E10	Because of your problem, have you been embarrassed in front of others?			
P11	Do quick movements of your head increase your problem?			
F12	Because of your problem, do you avoid heights?			
P13	Does turning over in bed increase your problem?			
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?			
E15	Because of your problem, are you afraid people may think that you are intoxicated?			
F16	Because of your problem, is it difficult for you to go for a walk by yourself?			
P17	Does walking down a sidewalk increase your problem?			
E18	Because of your problem, is it difficult for you to concentrate?			
F19	Because of your problem, is it difficult for you to walk around your house in the dark?			
E20	Because of your problem, are you afraid to stay home alone?			
E21	Because of your problem, do you feel handicapped?			
E22	Has your problem placed stress on your relationship with members of your family or friends?			
E23	Because of your problem, are you depressed?			
F24	Does your problem interfere with your job or household responsibilities?			
P25	Does bending over increase your problem?			