FYZICAL Therapy & Balance Centers

A Certified McKenzie Spine and Extremity Care Clinic

Spelled different because we are different

www.FYZICALCT.com

Appointment Date & Time: _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

SSN: _____

Address: _____
Street

_____ _____ _____
City State Zip

Sex: M ☐ F ☐

Patient Employer: _____

Employer Address: _____

_____

Responsible Party: _____

Relationship: _____

ACCIDENT INFORMATION *(if applicable)*

Is this condition due to an accident? _____

Date of Injury: _____

Type of accident: Auto ☐ Work ☐

Claim #: _____

Case Worker: _____

Attorney Name: _____

Phone: _____

Who referred you to FYZICAL? _____

Have you had PT before? _____

Where? _____

CONTACT INFORMATION

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail Address: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

REFERRING PHYSICIAN

Name: _____

Phone: _____

Address: _____

_____

BRISTOL
72 Pine Street
Bristol CT, 06010
P (860) 585 – 5800
F (860) 585 – 5840

SOUTHINGTON
1090 Meriden-Waterbury Tpk
Southington, CT 06479
P (203) 272 – 8490
F (203) 272 – 8474

WALLINGFORD
20 Chapel Street
Wallingford, CT 06492
P (203) 741-9948
F (203) 741-9950

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HEALTH HISTORY FORM

Have you had any of the following medical or rehabilitative services for *THIS* injury/episode?

Chiropractor	☐	Occupational Therapy	☐
CT Scan	☐	Orthopedist	☐
EMG/NCV	☐	Physical Therapy	☐
ER Care	☐	Podiatrist	☐
General Practitioner	☐	X-Ray	☐
Massage Therapy	☐	MRI	☐
Myelogram	☐	Neurologist	☐

Do you now or have you had *ANY* of the following? *(Check all that apply)*

Asthma	☐	Bowel/Bladder problems	☐
Bronchitis	☐	Severe or frequent headaches	☐
Emphysema	☐	Vision or hearing difficulties	☐
Pacemaker	☐	Numbness or tingling	☐
Shortness of breath/chest pain	☐	Dizziness or fainting	☐
High Blood Pressure	☐	Sleeping difficulties	☐
Heart Attack	☐	Weight loss or energy loss	☐
Stroke/TIA	☐	Weakness	☐
Congestive Heart Disease	☐	Varicose Veins	☐
Blood Clot/Emboli	☐	Hernia	☐
Epilepsy	☐	Pins or metal implants	☐
Seizure	☐	Joint replacements	☐
Thyroid /Goiter	☐	Neck injury/surgery	☐
Anemia	☐	Shoulder injury/surgery	☐
Infectious Disease	☐	Elbow injury/surgery	☐
Diabetes	☐	Back injury/surgery	☐
Cancer	☐	Knee injury/surgery	☐
Chemo/Radiation	☐	Leg/ankle/foot injury/surgery	☐
Arthritis/swollen Joints	☐	Currently pregnant	☐
Osteoporosis	☐	Tobacco Use	☐
Gout	☐	Allergies	☐
Emotional/psychological problems	☐		

Medications(Name/Dosage/Frequency)**:**_____

_____

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PATIENT CONDITION

Reason for visit: _____

When did your current symptoms begin? _____

Have you been treated here before? Yes ☐ No ☐ When? _____

List any other information that would assist in your care:

_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for FYZICAL Therapy and Balance Centers to furnish medical care and treatment considered necessary and proper in diagnosing or treating my/his/her physical condition.
Signature: _____ **Date**: _____

PRIVACY NOTICE

By my signature below, I acknowledge that I have read a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

FINANCIAL POLICY

I hereby authorize FYZICAL Therapy and Balance Centers to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that by signing I am giving my permission for treatment. I also authorize FYZICAL Therapy and Balance Centers benefits to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance, if deemed necessary.

Our relationship is with you and not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all deductibles, coinsurance, and co-pays that are not covered by your insurance plan are your responsibility from the date(s) the services are rendered.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurances, and third-party payers, to FYZICAL. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

By signing, Patient agrees & understands all items outlined above.

_____ _____

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TREATMENT COMMITMENT

FYZICAL Therapy and Balance Centers care very much about each person we treat. We are committing to you, our patient, to deliver exceptional care, with exceptional results! We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you chose to take. Listed are some of your responsibilities as a patient at Fyzical:

1. **Attending, on time, all scheduled appointments.**
2. **Informing your therapist of your progress, each visit.**
3. **Compliance with your treatment plan developed by your therapist.**
4. **Asking questions when you do not understand and instructions given to you by our staff.**
5. **Notifying your therapist in advance of your next doctor's appointment.**

PATIENT MISSED APPOINTMENT POLICY

We strive to provide out patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of physical abilities is something everyone in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

TWO CANCELLATIONS OR NO-SHOW APPOINTMENTS WILL RESULT IN DISCHARGE FROM YOUR PHYSICAL THERAPY PROGRAM. By scheduling appointments and not attending, it limits the availability for our other patients in need of appointments. In addition, it will interfere with your ability to maximize your results with therapy. You may be required to obtain a new order from the referring physician and pay a ***$25 cancellation fee*** prior to any future appointments being scheduled.

With the exceptions of serious emergencies, it is expected that you keep all of your appointments. If you need to reschedule, we require 24-hour notice. In such cases, please call our office and arrange a makeup appointment with our front desk.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you!

By signing, Patient agrees & understands all items outlined above.

_____ _____

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Client Needs Screen (CNS)

1. Have you fallen 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 dizziness or imbalance?	__ Yes	__ No
5. Do you lose your balance when stepping up/down curbs or stairs/steps?	__ Yes	__ No
6. Do you have a difficult time walking in the dark?	__ Yes	__ No
7. Do you have difficulty hearing?	__ Yes	__ No
8. Do you have osteoporosis, osteoarthritis or joint pain?	__ Yes	__ No
9. Do you take bone and/or joint supplements?	__ Yes	__ No
10. Do you experience muscle aches, pains and/or muscle cramps?	__ Yes	__ No
11. Do you use cold, heat, or compression therapy at home?	__ Yes	__ No
12. Are you interested in learning how compression clothing with ice could help your condition at home?	__ Yes	__ No
13. Are you interested in learning how home heat and/or cold therapy could help your condition?	__ Yes	__ No
14. Do you have foot and/or ankle pain/discomfort?	__ Yes	__ No
15. Do you currently wear shoe inserts?	__ Yes	__ No
16. Are you interested in learning how a shoe insert could help your condition?	__ Yes	__ No
17. Do you have pain and/or physical challenges other then what you are being seen for today?	__ Yes	__ No
18. Would you like to get more information about whole body health?	__ Yes	__ No
19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	__ Yes	__ No

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