FYZICAL® RALEIGH
Therapy & Balance Centers

Today's Date: _____

Name: _____ Date of Birth: _____ SSN: _____

Phone Number: _____ Email: _____

Home Address: _____

Emergency Contact (Name and Phone): _____

How did you hear about us? ☐ Doctor ☐ Friend ☐ Internet ☐ Other_____

How would you like to receive reminders about your appointment? ☐ Text ☐ Phone call ☐ Email

Occupation_____ Work status? _____

Dominant hand ☐ Right ☐ Left ☐ Ambidextrous Height: _____ Weight:_____

Have you fallen in the last year? ☐ Yes ☐ No If yes, were you injured? ☐ Yes ☐ No

What problem or issue brings you here? _____

What daily activities are you having difficulty performing? _____

What are your goals for physical therapy? _____

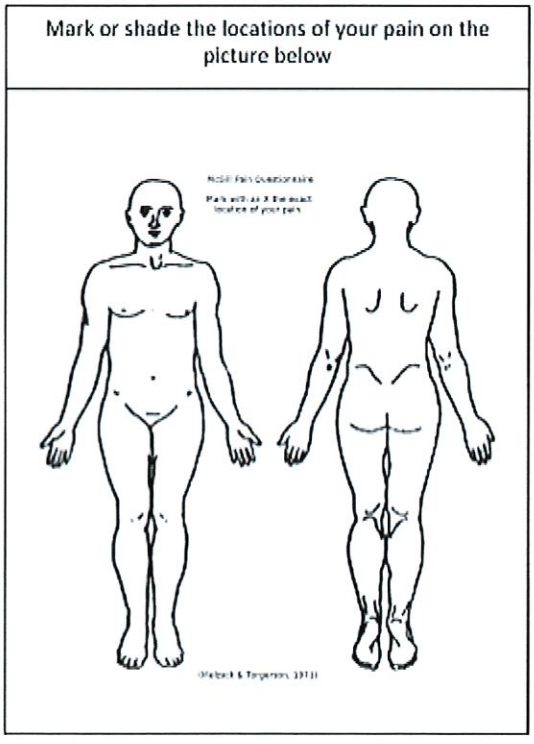
How and when did this issue start? _____

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

What tests have you had? ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Bone scan ☐ Other_____

What treatments have you had? ☐ Physical Therapy ☐ Massage ☐ Chiropractic ☐ Other _____

Mark or shade the locations of your pain on the picture below



**Please describe your pain or chief symptoms: (check all that apply)**

☐ Vertigo, room spinning
☐ Light headedness
☐ Imbalance
☐ Ear pressure/pain
☐ Motion intolerance
☐ Headaches/migraine
☐ Head injury/concussion
☐ Tingling
☐ Burning
☐ Shooting
☐ Throbbing
☐ Dull pain / ache

**Please describe the intensity and pattern of symptoms:**

Symptoms are...
☐ Getting better
☐ Not changing
☐ Getting worse

☐ Morning
☐ Afternoon
☐ Night
☐ Constant

Activities/positions that increase symptoms

_____

Activities/positions that decrease symptoms

_____

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**Place marks on lines to indicate your level of pain/ symptoms**
**0= no pain/symptoms 5= symptoms cause you to stop activities 10= must go to hospital**

Please rate your **CURRENT** level of pain or symptoms on the line below

----0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10----

Please rate your **BEST** level of pain or symptoms on the line below

----0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10----

Please rate your **WORST** level of pain or symptoms on the line below

----0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10----

Do you have difficulty hearing? ☐ Yes ☐ No Do you have hearing aids? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No Usual BP? _____

Do you have any joint replacements or metal implants? ☐ Yes ☐ No

Please list type and date:_____

Do you have a history of cancer or tumors? ☐ Yes ☐ No

Please list type and date: _____

Chemotherapy? ☐ Yes ☐ No Radiation? ☐ Yes ☐ No

Do you leak urine, even a small amount? ☐ Yes ☐ No

Do you have to rush to use the bathroom? ☐ Yes ☐ No

**Do you currently experience any of the following?**

| | | | |
|---|---|---|---|
| Recent night pain or fevers/ sweats | ☐ Yes ☐ No | Sleep problems | ☐ Yes ☐ No |
| Vision change or double vision | ☐ Yes ☐ No | Depressed mood | ☐ Yes ☐ No |
| Unintentional weight change | ☐ Yes ☐ No | Anxiety | ☐ Yes ☐ No |
| Shortness of breath | ☐ Yes ☐ No | Joint swelling | ☐ Yes ☐ No |
| New rashes / psoriasis | ☐ Yes ☐ No | Nausea, vomiting, bowel or bladder changes | ☐ Yes ☐ No |

WOMEN: Pregnant? ☐ Yes ☐ No Est. date of delivery:_____ Number of pregnancies? _____

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**Medical History** 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 doctor in more thoroughly understanding your state of health

| CONDITION | PAST | PRESENT | CONDITION | PAST | PRESENT |
|---|---|---|---|---|---|
| Angina | ☐ | ☐ | Systemic Lupus | ☐ | ☐ |
| Chest pain | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Osteoarthritis | ☐ | ☐ |
| Cardiac Problems | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Stroke/TIA | ☐ | ☐ | Peripheral neuropathy | ☐ | ☐ |
| Blood Clot | ☐ | ☐ | HIV/AIDS | ☐ | ☐ |
| Asthma / Respiratory | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Infectious diseases | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Epilepsy / seizures | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ | Lower limb edema/swelling | ☐ | ☐ |

Other Present or Past Medical Conditions: _____

**Current Medication List:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

*Please be advised we may have the medication list on file if you were referred from a physician's office, feel free to verify with the front desk if it is already on file. Thank you.*

Client Signature _____ Date_____

RBR PT, LLC DBA FYZICAL RALEIGH THERAPY BALANCE CENTER
1300 Corporation Parkway, STE B, Raleigh, NC 27610 Phone: 919-917-7729 Fax: 919-400-4178

# Authorization to Use and/or Disclose Health Information

Patient Name: _____ SSN: _____

Date of Birth: _____

1. I authorize the use and disclosure of the above individual's health information as described below:
   a. The following individual or organization is authorized to make the disclosure:
   Fyzical Raleigh
   1300 Corporation Pkwy Ste B Raleigh NC
   Phone: 919.917.7729 Fax: 919.400.4178

2. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):
   ☐ Office visits from (date) _____ to (date) discharge
   ☐ Lab results from (date) _____ to (date) _____
   ☐ X ray and imaging reports from (date) _____ to (date) _____
   ☐ Consultation reports from (MD's names) _____
   ☐ Entire record
   ☐ Other, please specify: evaluation & treatment notes

3. This information may be disclosed to and used by the following individual/organization:
   _____ *referring or
   _____ primary physician
   Phone: _____ Fax: _____

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the address above. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire on _____/_____/_____.

I understand that I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the FEDERAL PRIVACY RULE.

_____ _____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, Relationship to Patient: _____

_____ _____
Signature of Witness Date

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# Patient Acknowledgement Form

Please Read and Initial:

_____ I consent to evaluation and treatment by FYZICAL Therapy and Balance Center of Raleigh and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ The filling of insurance claims is a courtesy that we extend to our patients. **You will be responsible for any charges not reimbursed or contractually adjusted by your insurance company.** Should your claims not process as you expected or should you have any questions regarding your insurance plan benefits, please contact the receptionist.

_____ I authorize **phone, e-mail, and/or text messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ I have received and/or been offered a copy of this facility's **Notice of information/ Privacy Practices** has been provided to me.

_____ Medicare beneficiaries have an annual cap for combine therapy services including Physical, Occupational, and Speech Therapies.

_____ A $35.00 charge will be charged for any returned checks.

_____ I hereby assign to FYZICAL Therapy and Balance Center of Raleigh all payment for medical services rendered to myself or my dependants. In the case of a motor vehicle accident, I understand that it is my responsibility to furnish claim information in a timely manner. If claim information is not furnished by the third visit, then I consent to using my personal health insurance.

_____ **I understand I will be charged a fee of $20.00 for cancelled or missed appointments without 24 hour notice for Saturday appointments.**

_____ **I understand that any medical record requests and form completion requests, such as Short-Term Disability, may take 24-72 hours to be completed.**

_____ _____
Patient Signature Today's Date

_____ _____
Patient Legal Representative Today's Date