1027 Regents Blvd. Fircrest, WA 98466 Phone: (253) 301-3783 Fax: (253) 301-3254

Patient Information

Name_____ ☐ Male ☐ Female
First *Middle* *Last*

Date of Birth____/____/____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____
Street Address City State Zip

Email Address_____
By providing your email address below, you agree to receive email appointment reminders.

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____
Appointment reminders ☐ Yes, notify me by text or ☐ No, do not notify me by text

Emergency Contact:_____ Phone: (_____) _____-_____ Relation:_____

How did you hear about us?_____

Optimum Physical Therapy (OPT) Policies Insurance/Billing Information

Please Provide Optimum Physical Therapy with your Primary and Secondary health insurance information and a copy of your insurance card(s).

PRIMARY INSURANCE

Name of Subscriber:_____ _____Date of Birth____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insurance Co:_____ Phone: (_____) _____-_____

Subscriber #:_____Group#/Name:_____

Subscriber's Address:_____ Phone: (_____) _____-_____

SECONDARY INSURANCE

Name of Subscriber:_____ _____Date of Birth____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insurance Co:_____ Phone: (_____) _____-_____

Subscriber #:_____Group#/Name:_____

Subscriber's Address:_____ Phone: (_____) _____-_____

WORKER'S COMPENSATION CARRIER

Employer:_____ Occupation:_____
(REQUIRED FOR WORKER COMPENSATION CASES)

Carrier:_____Claim #_____

Adjuster's Name:_____ __ Ph: (_____) _____-_____

Please complete reverse side

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Optimum Physical Therapy (OPT) Policies

Carefully read the following information. If you have any questions, please discuss them with us.

Payment Policy: As a courtesy, Optimum Physical Therapy (OPT) has verified your insurance benefits and we will bill your primary insurance carrier for you. Please remember that you are ultimately responsible for payment of all services rendered. Your portion of payment: Private pay, co-payment, co-insurance and/or deductible payments are required at time of service for each visit. I certify the information supplied on this form is true to the best of my knowledge. I will notify Optimum Physical Therapy of any changes in the listed information. I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand and agree that if it becomes necessary to commence legal actions for the collection of outstanding charges on my account. I will be responsible for any costs and/or court fees in addition to the outstanding balance.

I hereby authorize Optimum Physical to furnish my insurance carrier(s) any and all requested information concerning my health. I also authorize my insurance carrier(s) to pay Optimum Physical Therapy directly for any services rendered. I have read the above policy and I acknowledge that I am ultimately responsible for payment of all services rendered.

Signature: _____ Date: _____/_____/_____
(Patient or Legal Guardian)

Privacy Policy:
I have received/reviewed a copy of OPT's Health Insurance Privacy Policy. _____(initial).
(POSTED AT RECEPTION DESK, COPY AVAILABLE UPON REQUEST)

Cancellation Policy: I understand that physical therapy is an on-going process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or accept an abbreviated treatment for the day. I also understand that failure to give 24 hour advanced notice of cancellation may result in a $25 fee _____***(initial)***.

Authorization of Release of Specific Information

Initial all statements that apply:

_____I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

_____I authorize you to discuss my appointments with my spouse/partner_____.

_____In addition to my referring doctor, I authorize you to communicate with and send reports and evaluations to the following:

_____

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Medical History

Last Name: _____ **First Name:** _____ **M.I.** ____ **Age:**_____

Height:_____ Weight:_____ Occupation:_____ ☐Male ☐Female

GOALS for Physical Therapy:_____

I CURRENTLY HAVE, OR HAVE HISTORY OF: (Check all that apply)

Neurologic

☐Migraine
☐Stroke/TI When? _____
☐Parkinson's Disease
☐Seizures/Epilepsy
☐Concussion/Head Injury When?_____
☐Multiple Sclerosis
☐Alzheimer's/Dementia
☐Other Neurologic_____

Cardiovascular

☐Angina/Nitroglycerin
☐Heart Attack When?_____
☐Peripheral Vascular Disease
☐High Blood Pressure
☐Low Blood Pressure
☐Other Cardiovascular_____

Respiratory

☐ Allergies
☐Emphysema/COPD
☐Asthma
☐Breathing Difficulties
☐Other Respiratory_____
☐ Other Health Issues

_____
_____
_____

Orthopedic

☐Artificial joints Which?_____
☐Arthritis
☐Osteoporosis/Osteopenia
☐Back Problems
☐Back Surgery When?_____
☐Neck Problems
☐Other Orthopedic

Vision

☐Cataracts, if removed, when?_____
☐Glaucoma
☐Macular Degeneration
☐Other Vision

Other

☐Cancer? Type?_____
☐Diabetes
☐Neuropathy
☐Depression
☐Anxiety
☐Thyroid Disease
☐Gastrointestinal Problems
☐Rheumatoid Arthritis
☐Tobacco use, how much_____
☐Marijuana use, how much _____
☐Alcohol use, how much_____
☐Unexplained weight loss/gain(>10 lbs)

All Patients:	Over the last two weeks have you had thoughts of suicide?	☐ Yes ☐ No
Females:	I have had a pelvic exam (PAP) within the last 12 months	☐ Yes ☐ No
	I have had a mammogram or breast exam within the last 12 months	☐ Yes ☐ No
	I am or may be PREGNANT	☐ Yes ☐ No
Males:	I have had a prostate exam within the last 12 months.	☐ Yes ☐ No

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Medications & Supplements

List **Prescriptions, Over the Counter Medications, Supplements & Vitamins** you are **currently**, or have **recently** taken (or provide a list):

NAME	DOSAGE	FREQUENCY	ROUTE	REASON

I give consent to Optimum Physical Therapy to provide physical therapy services to me, my child or my legal ward. I attest the above information provided is accurate to the best of my knowledge.

Signature: _____ **Date:** _____/_____/_____
(Patient or Legal Guardian)

Patient Questionnaire

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____

How long did it last? _____

I. **Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.**

YES	NO	
☐	☐	Do you experience motion, air or sea sickness?
☐	☐	Did you have motion sickness as a child?
☐	☐	Do you have a family history of motion sickness? parent? _____ sibling? _____ child? _____
☐	☐	Do you have migraine headaches?
☐	☐	Where you exposed to any solvents, chemicals, etc.?
☐	☐	Have you ever fallen? How many times? _____Where? _____
☐	☐	Are you afraid of falling?

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II. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please got to the next section (III).

YES	NO	
☐	☐	My dizziness is constant? If you answered yes, please go to section III.
☐	☐	If in attacks, how often? _____
☐	☐	Are you completely free of dizziness in between attacks?
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Is the dizziness provoked by head/body movement? If so, which direction? _____
☐	☐	Is the dizziness worse at any particular time of the day?
		If so, when? _____
☐	☐	Do you know of anything that will stop or make your dizziness better?
		What? _____
☐	☐	Do you know of anything that will stop or make your dizziness worse?
		What? _____
☐	☐	Do you know of anything that will precipitate an attack?
		What? _____
☐	☐	Do you know of possible cause for your dizziness?
		What? _____

III. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
☐	☐	Light headedness?
☐	☐	Swimming sensation in the head?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Tendency to fall to the right or left?
☐	☐	Tendency to fall forward or backward?
☐	☐	Loss of balance when walking veering to the right?
☐	☐	Loss of balance when walking veering to the left?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you have problems turning to one side or the other?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?
☐	☐	Recent cold or infection?
☐	☐	Recent head trauma?
☐	☐	Ringing in the ears (i.e. tinnitus)

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IV. Have you ever experience any of the following symptoms? Please check the box either YES or NO and circle if Constant or if In Episodes.

YES	NO			
☐	☐	Double vision?	Constant	In Episodes
☐	☐	Blurred vision or blindness?	Constant	In Episodes
☐	☐	Spots before your eyes?	Constant	In Episodes
☐	☐	Numbness of face, arms or legs?	Constant	In Episodes
☐	☐	Weakness in arms or legs?	Constant	In Episodes
☐	☐	Confusion or loss of consciousness?	Constant	In Episodes
☐	☐	Difficultly in swallowing?	Constant	In Episodes
☐	☐	Tingling around the mouth?	Constant	In Episodes
☐	☐	Difficulty Speaking	Constant	In Episodes

V. Do you have any of the following? Please check the box for either YES or No and circle the ear involved.

YES	NO				
☐	☐	Difficulty hearing?	Both Ears	Right Ear	Left Ear
		When did this start?_____	Is it getting worse? _____		
		Does the hearing change with your symptoms? If so,how? _____			
☐	☐	Noise in your ears?	Both Ears	Right Ear	Left Ear
		Describe the noise_____			
		Does the noise change with your symptoms? If so, how? _____			
☐	☐	Does anything stop the noise or make it better? What?_____			
☐	☐	Fullness or stuffiness in your ears?	Both Ears	Right Ear	Left Ear
		Does this change when you are dizzy?_____			
☐	☐	Pain in your ears?	Both Ears	Right Ear	Left Ear
☐	☐	Discharge from your ears?	Both Ears	Right Ear	Left Ear

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Dizziness Handicap Inventory (DHI)

Please mark an "X" in the appropriate box regarding your dizziness/imbalance symptoms

		YES	SOMETIMES	NO
P1	Does looking up increase your problem?			
E2	Because of you problem, do you feel frustrated?			
F3	Because of your problem, do you restrict your travel for business or recreation?			
P4	Does walking down the aisle of a supermarket increase your problems?			
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 the movies, dancing or going to parties?			
F7	Because of your problem, do you have difficulty reading?			
P8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?			
E9	Because of your problem, are you afraid to leave your home without having 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 homework or yard work?			
E15	Because of your problem, are you afraid people may think 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?			

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E21	Because of your problem, do you feel handicapped?			
E22	Has the problem placed stress on your relationships with members of your family or family?			
E23	Because of you problem, are you depressed?			
F24	Does your problem interfere with you job or household responsibilities?			
P25	Does bending over increase your problem?			

For Office Use Only **SCORE P:_____ E:_____ F:_____**	**16-3 Points (mild)** **36-52 Points (moderate)** **54+ Points (severe)**