BARROWS
TRAINING AND EDUCATION
PHYSICAL THERAPY
Where excellence and experience make a difference in your care.

Patient Name:	Date of Birth: Age:
Address:	Social Security Number:
City:	Marital Status: Married Single Widow Gender: Male Female
State:	Emergency Contact:
Zip Code:	Telephone number of Contact:
Primary Telephone:	Relationship to Contact:
Secondary Telephone:	Employer:
Email Address:	Employment Status:
How did you hear about us?	Referring Doctor:

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name:	Subscriber Name: Subscriber Social Security Number:
Member ID:	Subscriber Employer:
Group Number:	Subscriber Date of Birth: Relationship to Subscriber: Self Spouse Child Other

SECONDARY INSURANCE (if applicable)

Insurance Name:	Subscriber Name: Subscriber Social Security Number:
Member ID:	Subscriber Employer:
Group Number:	Subscriber Date of Birth: Relationship to Subscriber: Self Spouse Child Other

WORKERS COMPENSATION (if work related)

Insurance Name:	Claim Number:
Claims Adjuster:	Date of Injury:
Adjuster Telephone:	Claims Address:

AUTO INSURANCE (if auto related)

Insurance Name:	Insured/Claim Number:
Claims Adjuster:	Date of Injury:
Adjuster Telephone:	Claims Address:

Patient Information

Patients Last name: First: Middle:		Date of Birth / /	Age
Employer:(currently working: ☐Y ☐N) Years at Job:	**Occupation:** (last day worked:____) Hobbies/Activities:	**Dominant Hand** ☐R ☐L	**Gender** ☐M ☐F

Injury Information

What body parts were <u>initially</u> injured? 1.	2.
3.	4.

Describe how the injury happened:

Date of injury: **Your symptoms began:** ☐ Unknown ☐ Immediately ☐ Gradually

What treatments have you already received for this condition?

☐Surgery:_____ ☐Physical Therapy:_____
Date: ☐Chiropractic:_____
☐Injection:_____ ☐Other:_____
Date:

What diagnostic test have you received for this condition? (*Please list approximate dates*) ☐ None

☐X-Ray:_____ ☐MRI:_____ ☐CT Scan:_____
☐Bone Scan:_____ ☐EMG/NCV:_____ ☐Lab Test:_____

What body parts are <u>currently</u> painful? 1.	2.
3.	4.

Have you ever had this problem before? ☐Yes ☐No **When**_____ **Treatment rec'd** _____

Since the injury/condition began your symptoms are: ☐Increasing ☐Decreasing ☐Not changing

How much of the day do you feel your symptoms: ☐Occasionally (10-25%) ☐Intermittent (26-50%) ☐Frequent (51-80%) ☐Constant (80-100%)

Choose below what most accurately describes your symptoms:

- ☐ Pain is annoying but able to perform all activities
- ☐ Pain is tolerant but may cause difficulty performing some activities
- ☐ Pain interferes with performance of all activities
- ☐ Pain is so severe that you are unable to perform any activities

Sleep: ☐ Good ☐Moderate ☐Difficult ☐Only with meds | Position: ☐Back ☐Side ☐Stomach

What makes your injury/conditions feel better or worse? Use "**O**" for better, "**X**" for worse

___Nothing ___Sitting ___Standing ___Walking ___Running ___Stairs
___Movement ___Exercise ___Stretching ___Medication ___Lying Down ___Kneeling
___Twisting ___Bending ___Lifting ___Writing ___Keying ___Coughing
___Rest ___Sneezing ___Repetitive Hand Motion ___Other: _____

Symptoms are <u>worst</u>: ☐AM ☐Mid-day ☐PM | **Symptoms are <u>best</u>:** ☐AM ☐Mid-day ☐PM

Medical History

Please list any prescription medications you are currently taking: (including pills, injections, &/or skin patches)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any over-the-counter medications you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Do you smoke? ☐Yes ☐No

Do you have a pacemaker? ☐Yes ☐No

FOR WOMEN: Are you currently pregnant or think you might become pregnant? ☐Yes ☐No

Have you ever been diagnosed with having any of the following?

☐ Cancer	☐ Diabetes	☐ High blood pressure
☐ Circulatory problems	☐ Asthma	☐ Emphysema/Bronchitis
☐ Thyroid problems	☐ Heart Problems	☐ Multiple Sclerosis
☐ Rheumatoid arthritis	☐ Other arthritic conditions	☐ Osteoporosis
☐ Stroke	☐ Tuberculosis	☐ Depression
☐ Kidney disease	☐ Anemia	☐ Hepatitis
☐ Chemical dependency (drugs)	☐ Epilepsy	☐ Other: _____

Have you recently noted any of the following?

☐ Weight loss/gain	☐ Nausea/vomiting	☐ Dizziness/lightheadedness
☐ Fatigue	☐ Unusual weakness	☐ Fever/chills/sweats
☐ Numbness or tingling	☐ Abdominal pain	☐ Headaches
☐ Chest Pain	☐ Vision/eye problems	☐ Hearing problems
☐ Unusual joint/muscle swelling	☐ General arm/leg swelling	☐ Excessive bleeding/easy bruising
☐ Difficulty breathing	☐ Regular/persistent cough	☐ Difficulty swallowing
☐ Problems sleeping	☐ Sexual difficulties	☐ Night sweats
☐ Heart racing in your chest	☐ Heartburn/indigestion	☐ Post menopause
☐ Constipation/diarrhea	☐ Blood in stool	☐ Blood in the urine
☐ Problems urination (difficulty)	☐ Urinary incontinence	☐ Pregnant (or think you might be)
☐ Stress at home or work	☐ Tremors	☐ Seizures
☐ Skin problems (ex: rash, redness)	☐ Neck/back pain	☐ Wheezing
☐ Pain with sweats	☐ Shortness of breath	☐ Other: _____

Please list any allergies we should know about:

Please list any surgeries or other conditions for which you have been hospitalized: (include approx. dates)

Please list any significant injuries for which you have been treated in the past: (include approx. dates)

During the past month have you been feeling down, depressed or hopeless? ☐Yes ☐No

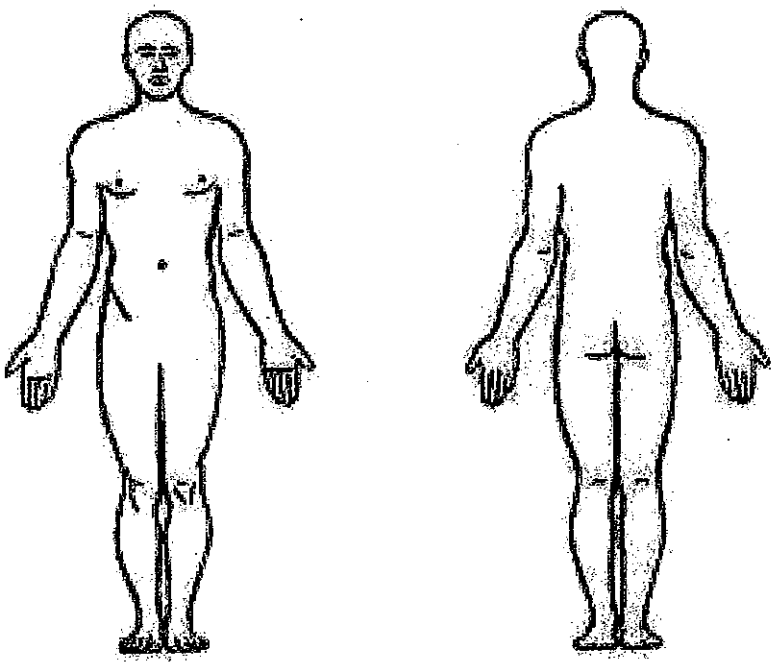
During the past month have you been often been bothered by little interest or pleasure in doing things that you enjoy? ☐Yes ☐No

Is this something with which you would like help? ☐ Yes ☐ Yes, but not today ☐ No

Body Chart:

Please mark the areas where you
Feel symptoms on the chart to the right
With the following symbols to describe
Your symptoms:

↓Shooting/sharp pain
ODull/aching pain
✚Numbness
=Tingling



I would rate my pain **CURRENTLY** as:

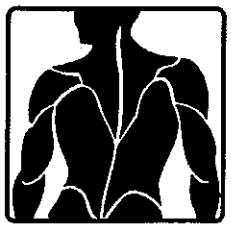
0	1	2	3	4	5	6	7	8	9	10
(none)		(annoying)		(uncomfortable)			(horrible)		(excruciating)	

The **LEAST** pain I have had **IN THE LAST WEEK** is:

0	1	2	3	4	5	6	7	8	9	10
(none)		(annoying)		(uncomfortable)			(horrible)		(excruciating)	

The **WORST** pain I have had **IN THE LAST WEEK** is:

0	1	2	3	4	5	6	7	8	9	10
(none)		(annoying)		(uncomfortable)			(horrible)		(excruciating)	



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ACKNOWLEDGEMENT AND CONSENT OF PRIVACY PRACTICES ACT

I understand Barrows Physical Therapy may use or disclose my personal health information, for the purposes of carrying out treatment, obtaining payment or evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Barrows Physical Therapy will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in the Barrows Physical Therapy Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Practice in writing at any time.

I further acknowledge that a copy of the current notice will be available upon request.

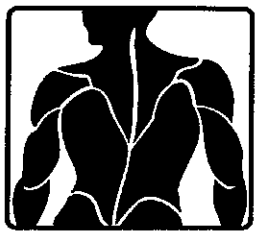
Signature _____ Date _____

If not signed by patient, please indicate relationship:

❑ Parent or guardian of minor	❑ Guardian or conservator	❑ Beneficiary or personal representative

Please print below anyone you wish to release information on your behalf:

Name	Relationship
Name	Relationship
Name	Relationship



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MADERA: 500 E. ALMOND AVE., STE 5B 93637
(559) 674-7201 FAX (559) 674-1338

FRESNO: 6049 NORTH FIRST STREET, STE 104 93710
(559) 438-0355 FAX (559) 438-0359

OFFICE POLICIES

We would like to welcome you as a patient of Barrows Physical Therapy. We strive to provide you the best personal care available. To help us do this it is important for you to participate in your care and follow these important policies. Please read them carefully, initial ALL proper spaces, and indicate your agreement by signing the bottom.

Please Initial

_____ If you are ill and you know that you are contagious, please call our office ASAP to re-schedule your appointment and avoid your cancellation fee of $35.00.

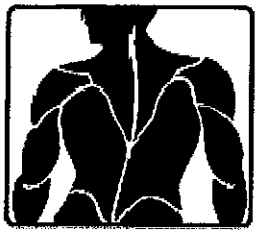
_____**Medicare Patients:** To avoid a personal fee of $60, please do not schedule X-rays and Physical therapy on the same day, as stated under Medicare guidelines.

_____**Cellular Phone:** We ask that you turn your cell phone off or switch it to vibrate. Please refrain from answering your phone during treatment to prevent therapy distractions.

_____Payment is expected at the time of your visit. It will include but not limited to any unmet deductible, co-insurance or co-payment amount. For your convenience Barrows Physical Therapy accepts Visa, Mastercard, Discover, Amex, Cash or personal check. Note: a $25 fee will be placed on all returned checks payable by cash or money order prior to receiving additional services from our staff. At the conclusion of your care with us you may also be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly

_____ _____

Signature of Patient/Responsible Party **Date**



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ATTENDANCE/CANCELLATION POLICY

Good attendance is essential to receive the most benefit from your therapy program. Communication is extremely important to your care. Please make us aware of any concerns or questions you may have.

Please Initial Below

_____"Late Policy 10 minutes" Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. Though we will make every effort to fit you in, there are no guarantees since openings due to cancellations are unpredictable.

_____I understand that failure to keep my appointments may result in the therapist discussing this with my doctor and may result in discharge. Three or more "no-shows" will result in an automatic discharge and my doctor and insurance (if required) will be notified.

_____If I wish to change or cancel an appointment Barrows Physical Therapy requires a minimum 24-hour advance notice. Anything less will result in a $35 fee charged to my account. If I accumulate more than 1 of these charges I am aware that payment of at least 1 fee will have to be made before any other appointment can be scheduled. *****Your insurance carrier will not be held responsible for these charges (including Workers Compensation and HMO's)**

_____ _____

Patient Signature **Date**

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: _____ **Date:** _____

SECTION I

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1.	Does looking up increase your problem?	Yes[1]	No[2]	Sometimes[3]
E2.	Because of your problem, do you feel frustrated?	Yes[1]	No[2]	Sometimes[3]
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes[1]	No[2]	Sometimes[3]
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes[1]	No[2]	Sometimes[3]
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes[1]	No[2]	Sometimes[3]
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes[1]	No[2]	Sometimes[3]
F7.	Because of your problem, do you have difficulty reading?	Yes[1]	No[2]	Sometimes[3]
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes[1]	No[2]	Sometimes[3]
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes[1]	No[2]	Sometimes[3]
E10.	Because of your problem, have you been embarrassed in front of others?	Yes[1]	No[2]	Sometimes[3]
P11.	Do quick movements of your head increase your problem?	Yes[1]	No[2]	Sometimes[3]
F12.	Because of your problem, do you avoid heights?	Yes[1]	No[2]	Sometimes[3]
P13.	Does turning over in bed increase your problem?	Yes[1]	No[2]	Sometimes[3]
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1]	No[2]	Sometimes[3]
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes[1]	No[2]	Sometimes[3]
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1]	No[2]	Sometimes[3]
P17.	Does walking down a sidewalk increase your problem?	Yes[1]	No[2]	Sometimes[3]
E18.	Because of your problem, is it difficult for you to concentrate?	Yes[1]	No[2]	Sometimes[3]
F19.	Because of your problem, is it difficult for you walk around the house in the dark?	Yes[1]	No[2]	Sometimes[3]
E20.	Because of your problem, are you afraid to stay home alone?	Yes[1]	No[2]	Sometimes[3]
E21.	Because of your problem, do you feel handicapped?	Yes[1]	No[2]	Sometimes[3]

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes[1]	No[2]	Sometimes[3]
E23.	Because of your problem, are you depressed?	Yes[1]	No[2]	Sometimes[3]
F24.	Does your problem interfere with your job or household responsibilities?	Yes[1]	No[2]	Sometimes[3]
P25.	Does bending over increase your problem?	Yes[1]	No[2]	Sometimes[3]

SECTION II - Part II

Instructions: Put a check in the box that best describes you:

- ☐ **Negligible symptoms (0)**
- ☐ **Bothersome symptoms (1)**
- ☐ **Performs usual work duties but symptoms interfere with outside activities (2)**
- ☐ **Symptoms disrupt performance of both usual work duties and outside activities (3)**
- ☐ **Currently on medical leave or had to change jobs because of symptoms (4)**
- ☐ **Unable to work for over one year or established permanent disability with compensation payments (5)**

Therapist Use Only

Comorbidities:

☐Cancer
☐Diabetes
☐Heart Condition
☐High Blood Pressure
☐Multiple Treatment Areas
☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
☐Obesity
☐Surgery for this Problem
☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____