Vestibular Rehabilitation Program Questionnaire

Section Instructions: (Symptom Explanation Form)
Please circle all the words that describe your symptoms/feelings:

Reeling	**Whirling**	**Faint**
Giddy	**Undulating**	**Lightheaded**
Ringing/Tinnitus	**Ear pain/pressure**	**Visual disturbed**
Warm	**Anxious**	**Pain**
Unable to concentrate	**Floating**	**Drifting**
Off balance/unsteady	**Dazed**	**Falling**
Clumsy	**Fluttering**	**Sick**
Vomiting	**Swimmy-Head**	**Confused**
Swaying	**Disoriented**	**Heavy Headed**
Headache	**Weak**	**Spinning**
Listing	**Leaning**	**Lack of Memory**
A rush	**Fuzzy Headed**	**Shaky**
Nauseated	**Focus Problems**	**Being Pulled**
Staggering	**Spacey**	**Vertigo**
Fatigued	**Drunk**	**Blurry Vision**

Other:

If you have symptoms other than those above, please indicate below:

Are your symptoms constant or intermittent?

If intermittent, how long are the symptoms lasting?

PATIENT INFORMATION	How did you hear about us?:	
Last Name:	Date of Birth:	Male/Female
First Name:	Phone #: Home/Mobile	
Middle Name:	Marital Status: Single Married Other	
Address:	Employer name/School name:	
City, State, Zip:	Email Address:	
Employment Status: Employed FT Student PT Student N/A	Title/Position:	
REFERRING PHYSICIAN INFORMATION	Address:	
Last Name: First:	Phone #:	
EMERGENCY CONTACT/LEGAL GUARDIAN INFORMATION		
Last Name:	First Name:	Date of Birth:
Address:	Phone #: Home/Mobile:	
City, State, Zip:	Relationship:	
REASON FOR TODAY'S VISIT		
Job Car Home Other	Date of accident/injury:	
Other:	Date of illness (1st symptom):	
Insurance adjuster name or contact: Phone #:		
RESPONSIBLE PARTY STATEMENT		
As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility		
Responsible Party Signature:	Date:	

INSURANCE INFORMATION		
Primary:	Group:	ID Number:
Policyholder (*if other than patient):*		Date of Birth:
Address: City, State, Zip		Relationship to Patient
Secondary:	Group:	ID Number:

Dizziness Handicap Inventory

Name:_____ Date:_____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. For each question, please check "Yes", "No", or "Sometimes" as it pertains to your dizziness or unsteadiness only.

No.	Questions		Yes	No	Sometimes
1	Does looking up increase your problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problem?	P			
5	Do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties?	F			
7	Do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9	Are you afraid to leave your home without having someone accompany you?	E			
10	Because of your problem, are you embaarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Is it difficult for you to do strenuous housework or yard work?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Is it difficult for you to walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Is it difficult for you to concentrate?	E			
19	Is it difficult for you to walk around your house in the dark?	F			
20	Are you afraid to stay at home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has your problem placed stress on your relationships with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
			x4	x0	x2
	Total				

Falls Efficacy Scale

Name _____ Date _____

On a scale of 1 to 10, with

1 being very confident, and

10 being not confident at all,

how confident are you that you can do the following activities without falling?

Activity	Score 1 very confident 10 not confident at all
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals not requiring carrying heavy or hot objects	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off the toilet	
Total Score	

A total score of greater than 70 indicates that the person has a fear of falling.

Patient: _____ Age: _____

Diagnosis or Problem Area: _____

Please complete this questionnaire so that we are able to provide you the best possible care. Check any problems below that you have now and/or have had trouble with in the past, and please check if you have a family history.

Self	Family		Self	Family	
____	_____	Chest Pain	____	_____	Osteoarthritis
____	_____	Heart Disease	____	_____	Rheumatoid Arthritis
____	_____	High/Low Blood Pressure	____	_____	Hepatitis
____	_____	High Cholesterol	____	_____	Blood Clots
____	_____	Poor Circulation	____	_____	Diabetes
____	_____	Difficulty Breathing	____	_____	Bleeding/Bruising Easily
____	_____	Tuberculosis	____	_____	Hearing Impairment
____	_____	Respiratory Disease	____	_____	Visual Impairment
____	_____	Numbness to Hands and Feet	____	_____	Skin Rash/Disease
____	_____	Head Injury	____	_____	Dizziness
____	_____	Stroke	____	_____	Cancer
____	_____	Seizures	____	_____	Allergies
____	_____	Difficulty with Balance	____	_____	Osteoporosis
____	_____	Frequent Falls	____	_____	Bowel/bladder Problems
____	_____	Blackouts	____	_____	Headaches

Have you experienced any of the following in the past 3 months?

Change in health	Yes	No	Change in appetite	Yes	No
Nausea/vomiting	Yes	No	Difficulty swallowing	Yes	No
Fever/chills/sweats	Yes	No	Night pain	Yes	No
Unexplained weight change	Yes	No	Unusual fatigue	Yes	No

Do you smoke? _____ If so, how much? _____

Do you drink alcohol? _____ If so, how much? _____

Do you exercise? _____ If so, how often? _____

Do you get short of breath with exertion (up/down stairs)? _____

Women, is there any chance of pregnancy? _____

Do you have any other orthopedic injuries? _____

_____

Please list any surgeries or hospitalizations: _____

_____

Please list (or bring in a copy of) any medications or supplements you are currently taking: _____

_____

_____

Do you have any other special problems/concerns we should know about?

_____

_____

_____ _____ _____

Patient Signature Parent / Guardian Signature Date

VESTIBULAR PATIENTS EXPERIENCING DIZZINESS OR IMBALANCE ONLY MAY DISREGARD THIS PAGE IF NOT APPLICABLE

On the scales below, please circle the number which best represents the severity of your pain.

Currently:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Least amount of pain in the last 48 hours:

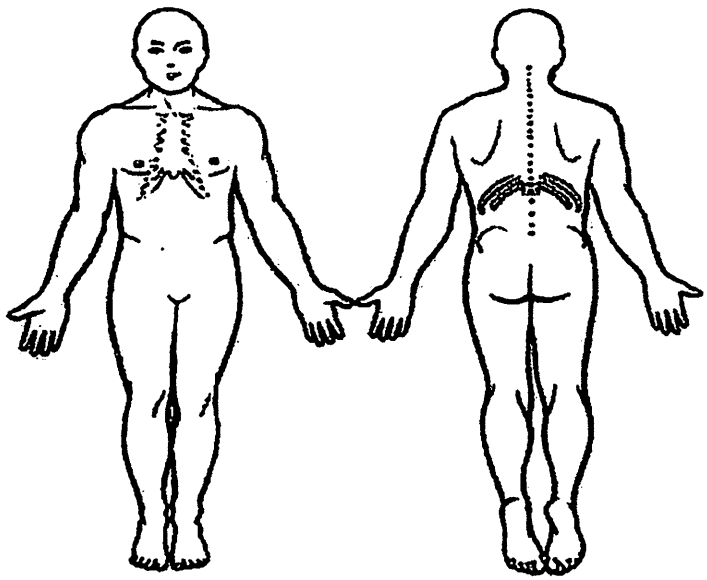
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Most amount of pain in the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Body Chart:

Please mark the areas where you feel pain on the chart to the right.



Please circle the number below which best represents your overall average level of function.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

What makes your symptoms better?

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____

Welcome to Action Reaction Physical Therapy, Inc.!

KNOW YOUR INSURANCE: Your insurance policy is a contract between you and your insurance company. Insurance policies vary, even within the same company. Your insurance company has the final say on what is covered and not covered under your policy. Even though we verify coverage or eligibility for you, ultimately, it is your responsibility to know what your coverage is for services. All questions about your coverage should be directed to your insurance company.

All services you receive here are transactions between you and your health care provider. If the services are not covered by your insurance, you may ultimately be responsible for the cost of these services.

MOTOR VEHICLE INSURANCE: We will bill your open MVA claim. It is recommended that you call your insurance company to verify the amount of coverage and how much is available on your claim. In the event that coverage for services on your plan is for "reasonable and customary," you will be responsible for the amount not paid by the insurance company.

THIRD PARTY INSURANCE: In the event your motor vehicle accident involves third party insurance, you may be charged a $50 lien filing fee. This fee will cover the cost of filing the lien, renewing and releasing the lien once a settlement and payment have been received.

WORKERS COMPENSATION CLAIMS: We will bill your open, approved workers compensation claim. Please be advised that in the event your claim is denied, you are financially responsible for all charges.

PAYMENT OPTIONS: We accept personal checks, debit, cash, Visa, MasterCard and Discover. Insurance co-payments are due at each visit. For all payments made in the clinic, a written receipt will be given to you per request. Any portion of your treatments that are not covered by your insurance becomes your responsibility, and is due within 30 days. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over 30 days old. Additionally, a $27.00 fee will be charged to the patient for each incident that a check is returned to us with insufficient funds.

SUPPLIES: We are a non-DME (durable medical equipment) provider and therefore, payment for supplies is due at time of service.

NON-DISCRIMINATION: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our office for services are protected against discrimination assured by the Title VI of the Civil Rights act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the information above or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

_____ _____

Patient Signature Date

Action Reaction Physical Therapy, Inc.
Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW CAREFULLY.

Action Reaction Physical Therapy, Inc. Legal Duty

Action Reaction Physical Therapy, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURE OF HEALTH INFORMATION

Action Reaction Physical Therapy, Inc. uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care provided. For example, Action Reaction Physical Therapy, Inc. may use your personal information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Action Reaction Physical Therapy, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any situation, Action reaction Physical Therapy, Inc's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop disclosures at any time.

Action Reaction Physical Therapy, Inc. may change its policy at any time When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request of list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we do not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Action Reaction Physical Therapy, Inc. will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

Concerns and Complaints

If you are concerned that Action Reaction Physical Therapy, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the U.S. Department of Health and Human Services or contact the following office:

Action Reaction Physical Therapy, Inc.
6300 Ninth Avenue N.E.
Suite 360
Seattle, WA 98115
(206) 523-6826

_____ _____

Patient Signature Date

Action Reaction Physical Therapy Cancellation and Missed Appointments Policy

We value your time and hope that you value our time as well. Appointments cancelled less than 24 hours in advance or missed appointments affect our community of patients and physical therapists.

A missed appointment means a physical therapist could not see a patient that might be needing care that day. Therefore, please make note of our cancellation and missed appointment policy below

- **You (not your insurance company) will be charged $50.00 for a missed appointment not cancelled at least 24 hours in advance of your scheduled visit**
- **$50.00 fee payable upon receipt of invoice**
- **Exceptions are limited to emergencies**

We provide reminder calls the day before your appointment as a courtesy. You are responsible for remembering your scheduled appointment at the time you make the appointment. Stating that you did not receive a reminder call or that the call was made after the 24 hour deadline does not make your missed or cancelled appointment an exception.

By signing the statement below, you are stating that you understand Action Reaction Physical Therapy's cancellation and missed appointment policy.

I, the undersigned have been informed about the Action Reaction Physical Therapy 24 hour cancellation and missed appointment policy. I understand that I will be charged and expected to pay Action Reaction Physical Therapy $50.00 for appointments not cancelled at least 24 hours in advance, or for any missed appointments.

I have been informed that reminder calls are made the day prior to my appointment as a courtesy, but that I am expected to remember my appointment at the time I make that appointment. (Reminder calls are often made less than 24 hours before the scheduled appointment time.)

_____ _____

Patient Signature Date

I opt out of receiving reminder phone calls _____

I'd rather receive email reminders _____ email address: _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREAT

I hereby assign all medical benefits to which I am entitled to Action Reaction Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Action Reaction Physical Therapy and may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Signature: _____ Date: _____