

Dear Patient,

Included in this packet are all the forms you will need to bring with you to your first appointment.

Please bring a prescription from your doctor requesting physical therapy, your insurance cards and a photo ID with you to your appointment.

The clinic is open each morning at 9am. Please be aware that the clinic is closed before 9 am each day and between 11:00 am and 12:30 pm on M, W and F. If your appointment is the first appointment in the morning or after lunch, please be aware that the clinic doors will be locked before 9am and during lunch.

Please be advised, that if for any reason you need to cancel your appointment we require a 24 hour notice. *A \$50 fee will be charged for any **no shows**, and a \$25 fee for any **cancellations that occur without 24 hours notice and any cancellations that occur after 3 cancellations.** All no show and cancelation fees are the **direct responsibility of the patient.** Insurance will not pay these fees.*

Please fill out all sections included in your packet **completely** prior to your visit to ensure that the therapist is provided enough time to complete your evaluation. Your evaluation will be completed over the course of 2 visits, each one hour in length.

Please wear pants or shorts and shoes with non-slip soles. Your shoes should have heels no higher than a tennis shoe. Tennis shoes or similar are the best option if you have them available

For driving directions to the clinic, please go to www.equilibrium-bpc.com. Click on the "Location" page and enter your address in the Google maps link.

I look forward to meeting you.

Sincerely,

Amy M. Griffin, M.S., P.T.
Vestibular and Balance Rehabilitation Specialist
EQUILIBRIUM Balance Performance Center
Physical Therapy

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CANCELATION POLICY

Dear Patient,

Our office requests if an appointment needs to be cancelled, that we receive notice **no later than 24 hours** prior to the appointment.

There is no charge for cancellations made with notice provided 24 hours in advance.

There is also no charge for your first 3 late **CANCELLATIONS** made without the requested 24 hour notice.

Beginning with the 4th late **CANCELLATION**, and each there after, a **\$25.00 fee** will be assessed.

NO SHOW appointments, including your initial evaluation visit, will be assessed a **\$50.00** fee.

Late **CANCELLATIONS** for **INITIAL EVALUATIONS** will also be assessed a **\$50.00** fee.

CANCELLATIONS and **NO SHOW** fees are the patient's responsibility. Insurance will not pay these fees. Fees are due on or before your next appointment.

- If you reschedule your INITIAL EVALUATION and arrive as scheduled, \$25 of your late "**CANCELLATION**" fee may be waived. "**NO SHOWS**" will still be ASSESSED a \$50.00 fee. If you are not scheduled for another visit a bill will be mailed to you, due payable upon receipt.

Please understand that we value the time of ALL our patients. No show and late cancelled visits tie up the therapist's availability to provide needed services to dedicated patients.

Thank you,

EQUILIBRIUM Balance Performance Center
Physical Therapy and Pilates



Patient Consent/Acknowledgement Form

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to revise our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosure we have already made based on your prior Consent.

Equilibrium Balance Performance Center, PT, Inc. provides this form to comply with the Health Insurance Portability and Accountability Act (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- **Equilibrium Balance Performance Center, PT, Inc.** has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- **Equilibrium Balance Performance Center, PT, Inc.** reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information **but Equilibrium Balance Performance Center, PT, Inc.** does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosure will then cease.
- **Equilibrium Balance Performance Center, PT, Inc.** may condition the treatment upon the execution of this Consent.

Name: (*please print*): _____

Signature: _____ Date: _____

A copy of the "Notice of Privacy Practices" will be given to me at my request.

*PRIMARY PHYSICIAN: _____ PHONE (____) _____ - _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ - _____

*NEUROLOGIST: _____

*EAR NOSE & THROAT (ENT): _____

*CARDIOLOGIST: _____

PLEASE CHECK TO ALLOW EPBC, PT TO SEND A COPY OF YOUR EVALUATION TO YOUR DOCTORS LISTED ABOVE

VESTIBULAR AND BALANCE REHABILITATION QUESTIONNAIRE

DIAGNOSIS: (reason you are here): _____

Are you currently being seen by any of the following?

- Physical Therapist Speech Therapist Occupational Therapist Psychiatrist/Psychologist

If you are seeing any of the above, please describe the reason: _____

Have you had therapy for this recent illness? Yes No

If you answered yes, please explain where and when, and the outcome of the therapy: _____

INITIAL ONSET DATE OF SYMPTOMS/EXACERBATION: ____ / ____ / ____

- PRIMARY SYMPTOMS: imbalance dizziness vertigo (Sensation of spinning)
 (check all that apply) lightheaded spaciness tinnitus (ringing in ear)
 nausea vomiting Pressure in your head
 OTHER _____

WHAT CAUSED YOUR SYMPTOMS TO ONSET: _____

MEDICAL HISTORY RELATED TO YOUR CURRENT SYMPTOMS: _____

(check all that apply)

- Dizziness/Vertigo(circle one) recent past Motion sickness Family history of vertigo
 Trauma or blow to the head Loss of consciousness
 Ear infections (please specify): recent past childhood
 Headaches (please specify): recent past migraines
 Vision: blurry vision double vision
 glaucoma cataracts R-L other: _____
 Corrected with: surgery lenses monofocal – bifocal – trifocal
 Have you had any recent changes in your ears? Right Left Both
 Distortion in hearing?
 Difficulty hearing?
 Pressure/pain in your ears?
 Drainage from your ears?
 Noise in your ears?
 Describe: _____
 Neck Pain
 High **OR** Low blood pressure (*please circle one*)

SEVERITY OF SYMPTOMS: (rated 0-10) Dizziness ____ / 10 Imbalance ____ / 10

HAVE YOU EXPERIENCED ANY RECENT / SUDDEN CHANGES OF THE FOLLOWING:

- difficulty with bowel or bladder function
- numbness (hands, feet, mouth, or face)
- unexplained or sudden weakness
- unexplained or sudden weight change
- malaise (unusual fatigue / listlessness)
- unexplained or sudden vision / hearing problem onset / changes
- genital/anal area numbness
- fever/chills
- dizziness / fainting attacks
- night pain / sweats
- difficulty speaking

OTHER MEDICAL HISTORY: Have you had or do you suffer from: (Check all that apply)

- Heart problems _____
- Diabetes
- Stroke/Neurological
- Multiple Sclerosis
- Parkinson’s Disease
- Seizures/Convulsions
- Kidney disease
- Cancer
- Life threatening infection
- Cardiac/heart disease
- Fibromyalgia
- Rheumatoid Arthritis
- Depression
- Do you drink alcohol? Yes No how much? _____ Use tobacco? Yes No packs/day _____
- Use recreational drugs? Have a dependency on prescription drugs? Yes No how much? _____
- Recent flu/Virus (please specify): _____

Orthopedic conditions / surgeries – (please list) _____

CLINICIAN USE ONLY

MEDICATION

Are you currently taking any medication for your condition? _____

PREVIOUS LEVEL OF FUNCTION

Describe: _____

CURRENT LEVEL OF FUNCTION

Describe: _____

Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer “Yes”, “No”, or “Sometimes” to each question. **Please answer all the questions in the questionnaire; this will help ensure an accurate evaluation.**

Key: Y = Yes N = No S = Sometimes

| <u>Item</u> | <u>Question</u> | | <u>Y</u> | <u>N</u> | <u>S</u> |
|-------------|--|----------|--------------------------|--------------------------|--------------------------|
| 1. | Does looking up increase your problem? | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Because of your problem, do you feel frustrated? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Because of your problem, do you restrict your travel for business or recreation? | F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Does walking down the aisle of a supermarket increase your problem? | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Because of your problem do you have difficulty getting in/out of bed? | F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Does your problem significantly restrict your participation | F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Because of your problem, do you have difficulty reading? | F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Does performing more ambitious activities increase your problem? | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Because of your problem, are you afraid to leave home without someone accompanying you? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Because of your problem are you embarrassed in front of others? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Do quick movements of your head increase your problem? | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | Because of your problem, do you avoid heights? | F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | Does turning over in bed increase your problem? | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | Is it difficult for you to do strenuous housework or yard work? | F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | Because of your problem are you afraid people may think you are intoxicated? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | Because of your problem is it difficult for you to walk by yourself? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | Does walking down a sidewalk increase your problem? | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | Because of your problem, is it difficult for you to concentrate? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | Because of your problem, is it difficult for you to walk around your house in the dark? | F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | Because of your problem, are you afraid to stay home alone? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. | Because of your problem, do you feel handicapped? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | Has your problem placed stress on your relationships with members of your family or friends? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | Because of your problem, are you depressed? | E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. | Does your problem interfere with your job or household responsibilities? | F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. | Does bending over increase your problem? | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

CLINICIAN USE ONLY

| | | | |
|------------------|-----------|-----------|-----------|
| Sub Total | _____ | _____ | _____ |
| | <u>x4</u> | <u>x0</u> | <u>x2</u> |

Total _____

P _____

E _____

F _____

Total Score = _____

