The Therapy Institute
EXCELLENCE IN PHYSICAL THERAPY SINCE 1989

Patient Information Form

Patient Information

Last Name _____ First Name_____ MI____ Preferred Name_____

DOB____/____/_____ SS #_____-_____-_____ Sex_____ Marital Status_____

Address_____

Address #2_____ City_____ State_____ Zip_____

Email: _____ **How did you hear about us?** _____

Contact Information:

	Can we leave a message at number below
Home phone:	Y / N
Work phone:	Y / N
Cell Phone:	Y / N

Emergency Contact

Last Name_____ First Name_____ MI_____ Relationship_____

Phone_____

Employer

Name_____ Phone_____

Address_____

State_____ Zip_____

Problem

Problem Description_____ Date of Injury_____/____/_____ Last Physician Visit_____/____/_____

Referred By_____

Notes:_____

Did the injury happen at work? Y / N If yes, is this workers compensation?_____

Claim #_____ **Case Manager Name**_____ **Phone**___-_____-_____

Was injury related to Auto Accident? Y / N **If yes, what state did it occur in:**_____

Policy #_____ **Case Manager/Adjuster Name**_____ **Phone**_____-_____-_____

Primary Insurance

Insurance_____ Primary Subscriber Name_____ DOB_____

ID_____ Group #_____ Relationship_____

Secondary Insurance

Insurance_____ Primary Subscriber Name_____DOB_____

ID_____Group #_____Relationship_____

Tertiary Insurance

Insurance_____ Primary Subscriber Name_____DOB_____

ID_____Group #_____Relationship_____

HIPAA NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have received/been offered the Notice of Privacy Practices.

_____ _____/_____/_____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe relationship to patient:

_____

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION (Optional)

My protected health information may be disclosed to:

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand that, as set forth in The Therapy Instiute, LLC Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:
The Therapy Institute, LLC
1660 Haslett Rd, Ste 4
Haslett, MI 48840
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that The Therapy Institute, LLC has relied on the use or disclosure of the protected health information.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under the federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization

With my signature below I agree to the following:

- I authorize release of information requested by my insurance plan for payment.
- I understand that verification of insurance benefits is done as a courtesy and not a guarantee of payment, coverage, or benefits stated by my insurance carrier.
- I understand that I am financially responsible for any balance not covered by my insurance carrier.
- A copy of this signature is as valid as the original.

_____ Date_____/_____/_____

Signature of Patient or Personal Representative

_____ _____

Printed Name of Patient or Personal Representative Authority of Representative

Patient Name: _____ Date: _____

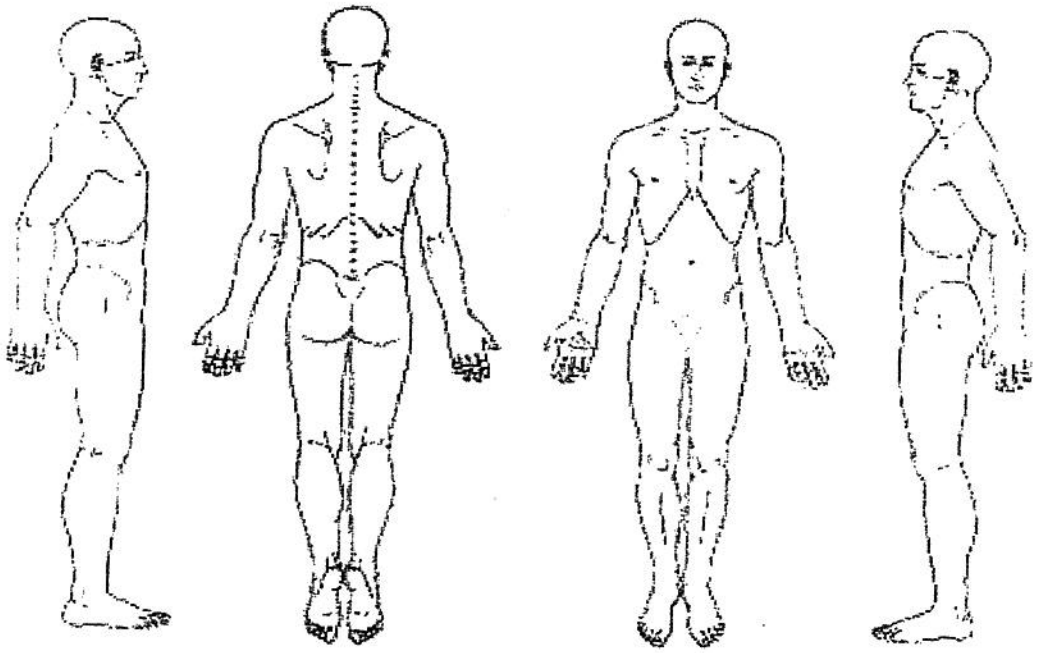
Medical History

Please list all of your relevant surgeries:

Please list any current medications you are taking:

Symptom Location

Please indicate on the body chart below where you are experiencing the symptoms that are bringing you into therapy TODAY. Previous symptoms and episodes will be reviewed by your therapist during your evaluation.



Patient Name: _____ DOB: _____ Date: _____

The Dizziness Handicap Inventory (DHI)

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. Answer as it applies to your dizziness or unsteadiness only.

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

Scoring Instructions

No = 0 Sometimes = 2 Yes = 4

16-34 points - Mild Handicap

26-53 points - Moderate Handicap

54 + points - Sever Handicap

Score: _____