SAWTOOTH
Physical Therapy

First Name _____ MI ___ Last Name _____

Date of Birth _____ Social Security # _____ Gender

Mailing Address _____ ☐ Male ☐ Female

_____

_____

Physical Address _____

_____

_____ Driver's Lic # _____

		OK To Call	Best Time To Call
Home Phone	_____	☐	_____
Work Phone	_____	☐	_____
Cell Phone	_____	☐	_____

Marital Status
☐ Divorced
☐ Separated
☐ Married
☐ Single
☐ Unknown
☐ Widowed

Employment Status
☐ Active Military
☐ Full-Time
☐ None
☐ Part-Time
☐ Retired
☐ Self Employed

Student Status
☐ Full-Time
☐ None
☐ Part-Time

Email Address _____

How would you like to receive Appointment Reminders?
☐ Text ☐ Email

Patient Employer _____
Address _____
_____
Phone _____
Occupation _____

Spouses Employer _____
Address _____
_____
Phone _____
Occupation _____

How did you hear about us?

☐ Physician
☐ Employer
☐ Case Manager
☐ Former Patient
☐ Adjustor
☐ School
☐ Hospital
☐ Cross Referral
☐ Attorney
☐ Self
☐ Screens - Open Houses
☐ Marketing Ad - Print
☐ Marketing Ad - TV
☐ Marketing Ad - Billboard
☐ Marketing Ad - Direct Mail - Email

Specify: _____ ☐ Friend/Family - Please list Name: _____

_____ _____

Signature of Patient Date

New Patient Information Form

Vestibular Medical History Form

Welcome to Sawtooth Physical Therapy LLC. Please take a moment to fill out your medical history as accurately as possible. Our goal is to ensure that you receive the best and most complete care possible, and this information is vital for us. Please write clearly and be aware that your therapist may verbally review this information with you.

Name: _____ Date of Birth:_____ Male Female

Occupation: _____

If a Minor

*Mother's Name*_____

*Work Phone*_____ *Social Security number* _____

Father's Name _____

*Work Phone*_____ *Social Security number* _____

Height_____ Weight_____

Who is your Primary Physician: _____

Would you like us to correspond with your primary care physician regarding your care here? YES NO

Who is your Referring Physician: _____

History of Current Illness/Subjective

Chief Complaint: _____

_____

Setting in which symptoms first occurred: _____

What makes it better? _____

What makes it worse? _____

Description of Symptoms: □ Vertigo (sense of spinning) □ off- balance □ Light headedness

Please rate on a scale from 1 (little problem) to 10 (couldn't be worse), how severe is this problem?
TODAY: _____/10 WORST: _____/10

Symptoms are getting: □ Better □ Worse □ Same □ Episodic

Description of spells: □ Constant □ Spontaneous □ Induced by motion □ Induced by position changes

Length of spells: □ Seconds □ Minutes □ Hours □ Days □ Other _____

Please check all that describe your symptoms:

□ Spinning
□ Lightheaded/swimming
□ Off Balance/unsteady
□ Blurry vision
□ Sense of tilting
□ Stiffness/pain in neck
□ Trouble walking
□ Nausea/vomiting

Have you experienced any of the following symptoms/sensations with your problem?

□ Difficulty swallowing
□ Blacking out/fainting
□ Headaches
□ Confusion
□ Numbness in arms or legs
□ Ringing of ears/tinnitus
□ Difficulty speaking
□ Tingling around face or mouth
□ Double or blurry vision

Hearing Impairments? □ Yes □ No □ Other _____

Recent falls: □ Yes (if yes, how many? _____) □ No

History of migraines? □ Yes □ No □ Comments _____

Previous treatments: _____

What are your goals for your rehabilitation? _____

Please list all prescription and over-the-counter medications you are currently taking? (Attach separate sheet if necessary).____
_____

For Women: Are you or might you be or become pregnant: □ Yes □ No

Do you have a pacemaker or any other implantable device: □ Yes □ No

Are you currently under a physician for any other conditions? If YES, what?
_____

Do you smoke? If YES, how many packs per day? _____

Do you drink alcohol? If yes, how often? □ Yes (□ daily, □ weekly, □ occasionally) □ No

Have you ever been diagnosed with any of the following conditions? Please check appropriate box

Cancer	□Yes	□No	**Rheumatic Arthritis**	□Yes	□No
Heart Problem	□Yes	□No	**Other Arthritic Conditions**	□Yes	□No
High Blood Pressure	□Yes	□No	**Anemia**	□Yes	□No
Circulation Problems	□Yes	□No	**Depression**	□Yes	□No
Multiple sclerosis	□Yes	□No	**Hepatitis**	□Yes	□No
Diabetes	□Yes	□No	**Tuberculosis**	□Yes	□No
Chemical Dependency	□Yes	□No	**Epilepsy/Seizures**	□Yes	□No
Asthma	□Yes	□No	**Osteoporosis**	□Yes	□No
Parkinson's	□Yes	□No	**Fibromyalgia**	□Yes	□No
Stroke	□Yes	□No	**Other**	□Yes	□No

Dizziness Handicap Inventory

SAWTOOTH Physical Therapy

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "always", or "no" or "sometimes" to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	No
P1	Does looking up increase your problem?	☐	☐	☐
E2	Because of your problem, do you feel frustrated?	☐	☐	☐
F3	Because of your problem, do you restrict your travel for business or pleasure?	☐	☐	☐
P4	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
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 movies, dancing or to parties?	☐	☐	☐
F7	Because of your problem, do you have difficulty reading?	☐	☐	☐
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	☐	☐	☐
E9	Because of your problem, are you afraid to leave your home 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 housework or yard work?	☐	☐	☐
E15	Because of your problem, are you afraid people may think that 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?	☐	☐	☐
E21	Because of your problem, do you feel handicapped?	☐	☐	☐
E22	Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
E23	Because of your problem, are you depressed?	☐	☐	☐
F24	Does your problem interfere with your job or household responsibilities?	☐	☐	☐
P25	Does bending over increase your problem?	☐	☐	☐

Is there any other information that would assist us in your care?

_____

_____

_____

Consent for Treatment

I, the undersigned, do hereby agree and give my consent for Sawtooth Physical Therapy LLC to furnish medical care and treatment as considered necessary and proper in diagnosing and treatment for my physical condition. I agree to promptly inform Sawtooth Physical Therapy LLC of any changes to this medical history.

Patient or Guardian Signature: _____Date:_____

Therapist Signature: _____Date:_____

MEDICAL INFORMATION MAY BE RELEASED TO: SPOUSE: _____

PARENT: _____OTHER: _____

PLEASE READ AND SIGN THE FOLLOWING:

I authorize the payment of insurance benefits to Sawtooth Physical Therapy LLC. I authorize the release of any information to and from any medical facilities, physicians, my insurance company, and to any person listed above in the medical information release section. I further agree that a photocopy of this agreement shall be as valid as the original. My signature below acknowledges that I have been offered a copy of the **Notice of Privacy Practices** for Sawtooth Physical Therapy LLC, and have been given a copy if requested. I agree to notify the office of any changes to my address, phone number, employment, and insurance. I understand that as a courtesy to all patients in the clinic, if I am more than 10 minutes late for an appointment it may be rescheduled and if a cancelation is not made at least 24 hours prior to a scheduled appointment, a $25 dollar charge will be submitted to my account. Furthermore I understand that I will be charged $50 for not showing to an appointment and I understand that multiple No-shows' or rescheduled appointments may be grounds for dismissal.

I HAVE READ THE ABOVE INFORMATION ON THIS SHEET AND HAVE AGREED:

SIGN HERE:_____DATE:_____

Patient/Guardian Signature

Financial Policy Statement

Thank you for choosing Sawtooth Physical Therapy LLC for your physical therapy needs. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign the Financial Policy. All patients must have one form of picture identification such as a valid driver's license.

Insured Patients:

Sawtooth Physical Therapy LLC will bill your insurance company solely as a courtesy to you. I understand that I am responsible for the entire account, less any insurance contractual agreements, when services are rendered. **Sawtooth requires that payment of your estimated share, including contractual co-pay's be made at the time of service.** In the event your insurance company requests a refund of payments made, you will be responsible for the amount refunded to your insurance company.

I hereby authorize my health insurance company to make payment directly to Sawtooth Physical Therapy LLC for any benefits I may receive. I realize that this may not represent the full payment for services rendered and that I will be held responsible for the balance due within 90 days.

I authorize release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

Cash Patients:

Full Payment for services is due at the time of services are rendered.

Workers Compensation:

If you are requesting we bill "Workers Compensation" for an established claim, please be advised that should your claim be denied, you will be responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Additionally, I understand that if I pay with a check, and it is subsequently dishonored, I will be responsible for the payment plus and bank processing fees incurred by ***Sawtooth Physical Therapy LLC.***

Patient/Guardian Signature: _____ Date: _____