ASCEND
Physical Therapy & Balance Center

*** For Existing/ Previous Patients Only:
□ I acknowledge that all personal information is the same and have no further changes necessary. **Signature:** _____

PATIENT INFORMATION

NAME	GENDER ☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH

ADDRESS

CITY | STATE | ZIP CODE

BILLING ADDRESS (if different from above)

CONTACT: Please check the number you prefer to be called at

☐ HOME ( ) _____ ☐ WORK ( ) _____

☐ CELL ( ) _____ ☐ EMAIL: _____

☐ I prefer appointment reminders be sent to my email

REFERRING DOCTOR

Name of Doctor who referred you: _____ Date of follow up visit with this Doctor: _____

This date is needed to send a progress report before your appointment

EMERGENCY CONTACT INFORMATION

NAME	RELATION TO PATIENT
PHONE ( )	ALTERNATE ( )

WORKERS COMPENSATION / ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO	WERE YOU INJURED ON THE JOB ☐ YES ☐ NO	DATE OF INJURY/ACCIDENT	CLAIM NUMBER

NAME OF INSURANCE CARRIER	PHONE ( )	FAX ( )
CLAIMS ADJUSTER	PHONE ( )	FAX ( )
NURSE CASE MANAGER	PHONE ( )	FAX ( )

HOW DID YOU HEAR ABOUT ASCEND PHYSICAL THERAPY?

PLEASE SELECT ALL THAT APPLY:

☐ DOCTOR: _____ ☐ INSURANCE: _____

☐ FAMILY or FRIEND: _____ ☐ INTERNET OR YELP: _____

☐ OTHER: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells how you can obtain access to this information.

As a patient, you have the following rights.

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information;
6. The right to a paper copy of this Notice.

We want to assure you that you medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private. A complete copy of our privacy practices is available at any time in our waiting room or upon request. If you have any questions about this notice please contact the following Privacy Officer.

Effective Date of this Notice: 01/01/2021
Contact Person: Joseph Park—Privacy Officer
12465 Lewis Street. Suite 101 Garden Grove, CA 92840
(714) 703-8477 Email: Joe@ascendpt.net

I, _____hereby acknowledge that I have had the opportunity to review a copy of this practice's *NOTICE OF PRIVACY PRACTICES*. I understand that if I have questions or complaints regarding my privacy rights that I may contact the privacy officer. I further understand that the practice will offer me updates to this *NOTICE OF PRIVACY PRACTICES* should it be amended, modified, or changed in any way during my course of treatment.

Patient's Signature: _____ **Date:** _____

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LATE CANCELLATION OR NO SHOW POLICY

A 24-hour notice is required for an appointment to be rescheduled. If you need to reschedule, please call our office to arrange for a make-up appointment in the same week of the original appointment.

In an instance of a cancellation without 24-hour notice or no-show to a scheduled appointment, we reserve the right to charge a $40 fee.

If there's an emergency, we understand and can make an exception. More than 3 late occurrences, late cancellations or no shows will result in day-to day call in basis in order to schedule appointments. We reserve the right to discontinue care due to non-compliance.

Patient's Signature: _____ **Date:** _____

CONSENT TO TREATMENT

I hereby consent to the therapeutic procedures outlined below, to be performed by Ascend Physical Therapy, Inc. and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Ascend Physical Therapy, Inc. or from any other source.

I certify that I have read, and understand, the above consent statements:

Patient's Signature: _____ **Date:** _____

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FACIAL NERVE PARALYSIS PATIENT INTAKE QUESTIONNAIRE

Patient Name: _____ **Age**: _____ **Date**: _____/_____/_____

Diagnosis or Cause of Facial Paralysis: □ Bell's palsy □ Acoustic Neuroma □ Ramsay Hunt □ Trauma □ Other

Side of Involvement: □ Right □ Left □ Both **Onset / Surgery**: _____

Occupation / Hobbies: _____

Initial Involvement:

- ❑ Onset was: O sudden O gradual
- ❑ I lost: O all movement O partial movement

Recovery Process:

- ❑ I began to see movement return _____ O weeks / O months later

Relevant Past Medical History (check all that apply):

Special Tests	Previous Treatment
☐ MRI / MRA ☐ Blood tests ☐ CT scan ☐ Evoked electromyography (EMG) ☐ Hearing test	☐ initially had antivirals / steroids ☐ physical therapy ☐ electrical stimulation ☐ acupuncture ☐ psychologist ☐ psychiatrist ☐ Botox Date of last Botox injection: _____ ☐ Plastic surgery

Functional Complaints (check all that apply):

☐ Pain/tightness (if so, where?)	
☐ Dry eyes	☐ Dizziness
☐ Excessive tearing	☐ Imbalance
☐ Difficulty eating/drinking	☐ Depressed
☐ Difficulty with speech/communication	☐ Altered feeling/sensation
☐ Headaches	☐ Altered taste
☐ Headaches	☐ Hearing loss
☐ Difficulty performing job/hobbies	☐ Avoiding social settings

Please list your goals:

1. _____
2. _____
3. _____
4. _____

How much caffeine (coffee, soda, iced tea, chocolate) **do you consume per day**? _____

Do you smoke? □ NO □ YES **Do you consume alcohol?** □ NO □ YES

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Please list all SURGERIES and dates: *(continue on back of page if necessary)*

Surgery	Date

Please list all SERIOUS ILLNESSES and dates: *(continue on back of page if necessary)*

Illness	Date

List your *CURRENT MEDICATIONS* (including over the counter, vitamins and herbs): ☐ **See attached list**

Medication/Vitamin/Herb	Dose	Frequency	Administration Route (for example: by mouth, injection, etc.)

PHYSICIAN INFORMATION: *List **all** doctors you would like to receive a copy of your physical therapy evaluation.*

Neurologist/ENT/Cardiologist/Gerontologist/Osteopath	**Address/Phone/Fax**	**Specialty**
Referring MD:		
Primary Care MD:		
Others MDs:		

I certify that the foregoing statements are true to the best of my knowledge and belief.

_____ _____

Signature of Patient Date

_____ _____

Reviewed by Physical Therapist Date

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FACIAL DISABILITY INDEX

Patient Name: _____ Date: _____________

Please circle the most appropriate response to the following questions related to problems with the function of your facial muscles. For each question, consider your function **during the past month**.

1. **How much difficulty did you have keeping food in your mouth, moving food around in your mouth, or getting food stuck in your cheek while eating?**
   - Usually did with:
     - 5 - no difficulty
     - 4 - a little difficulty
     - 3 - some difficulty
     - 2 - much difficulty
   - Usually did not eat because:
     - 1 - of health
     - 0 - of other reasons

2. **How much difficulty do you have drinking from a cup?**
   - Usually did with:
     - 5 - no difficulty
     - 4 - a little difficulty
     - 3 - some difficulty
     - 2 - much difficulty
   - Usually did not eat because:
     - 1 - of health
     - 0 - of other reasons

3. **How much difficulty did you have saying specific sounds while speaking?**
   - Usually did with:
     - 5 - no difficulty
     - 4 - a little difficulty
     - 3 - some difficulty
     - 2 - much difficulty
   - Usually did not drink because:
     - 1 - of health
     - 0 - of other reasons

4. **How much difficulty did you have with your eye tearing excessively or becoming dry?**
   - Usually did with:
     - 5 - no difficulty
     - 4 - a little difficulty
     - 3 - some difficulty
     - 2 - much difficulty
   - Usually did not speak because:
     - 1 - of health
     - 0 - of other reasons

5. **How much difficulty did you have with brushing your teeth or rinsing your mouth?**
   - Usually did with:
     - 5 - no difficulty
     - 4 - a little difficulty
     - 3 - some difficulty
     - 2 - much difficulty
   - Usually did not tearing because:
     - 1 - of health
     - 0 - of other reasons

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6. **How much of the time have you felt calm and peaceful?**
   - 6 - all of the time
   - 5 - most of the time
   - 4 - a good bit of the time
   - 3 - some of the time
   - 2 - a little of the time
   - 1 - none of the time

7. **How much of the time did you isolate yourself from people around you?**
   - 1 - all of the time
   - 2 - most of the time
   - 3 - a good bit of the time
   - 4 - some of the time
   - 5 - a little of the time
   - 6 - none of the time

8. **How much of the time have did you get irritable toward those around you?**
   - 1 - all of the time
   - 2 - most of the time
   - 3 - a good bit of the time
   - 4 - some of the time
   - 5 - a little of the time
   - 6 - none of the time

9. **How often did you wake up early or wake up several times during your nighttime sleep?**
   - 1 - every night
   - 2 - most nights
   - 3 - a good number of nights
   - 4 - some nights
   - 5 - a few nights
   - 6 - no nights

10. **How often has your facial function kept you from going out to eat shop or participate in family or social events?**
    - 1 - all of the time
    - 2 - most of the time
    - 3 - a good bit of the time
    - 4 - some of the time
    - 5 - a little of the time
    - 6 - none of the time

Scoring: Physical Function: $\frac{\text{Total Score (questions 1-5)} - N}{N} \times \frac{100}{4}$ Social Function: $\frac{\text{Total Score (questions 6-10)} - N}{N} \times \frac{100}{5}$

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Buena Park: 5832 Beach Blvd. #114 Buena Park, CA 90621 | P: 714-707-2699 | F: 714-784-2160

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SYNKINESIS ASSESSMENT QUESTIONNAIRE (SAQ)

Patient Name: _____ Date: _____

Instructions: Please answer the following questions regarding facial function, on a scale from 1-5, according to the following scale:

1 = seldom or not at all

2 = occasionally, or very mildly

3 = sometimes, or mildly

4 = most of the time, or moderately

5 = all the time, or severely

	Question	Score (1-5)
1.	When I smile, my eye closes	
2.	When I speak, my eye closes	
3.	When I whistle or pucker my lips, my eye closes	
4.	When I smile, my neck tightens	
5.	When I close my eyes, my face gets tight	
6.	When I close my eyes, the corner of my mouth moves	
7.	When I close my eyes, my neck tightens	
8.	When I eat, my eye waters	
9.	When I move my face, my chin develops a dimpled area	
	Office use only Sum of Scores 1-9	
	Office use only SAQ Total Score	

Summate scores for questions 1-9 /45 x 100 = SAQ Total Score

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