ASCEND
Physical Therapy & Balance Center

☐ **I acknowledge that all personal information is the same as my previous visit.**

Signature: _____

PATIENT INFORMATION

NAME	SEX ☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH

ADDRESS

CITY STATE ZIP CODE

BILLING ADDRESS (if different from above)

PHONE Please check the number you prefer to be called at	REFERRED BY:
☐ HOME ( ) _____	☐ DOCTOR _____
☐ CELL ( ) _____	☐ FRIEND _____
☐ WORK ( ) _____	☐ OTHER _____

EMAIL

☐ I prefer appointment reminders be sent to my email

MARITAL STATUS

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT INFORMATION

NAME	RELATION TO PATIENT

ADDRESS

CITY STATE ZIP CODE

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
	( )	( )

All services furnished are charged directly to the patient. Patients are financially responsible for payment unless other arrangements have been made with the office management. It is our policy that payment be made at the same time services are rendered. We do not render services on the basis that insurance companies are financially responsible.

CONSENT FOR TREATMENT

I hereby authorize my consent to be treated now and in the future by Ascend Physical Therapy.

PATIENT / INSURED SIGNATURE	DATE

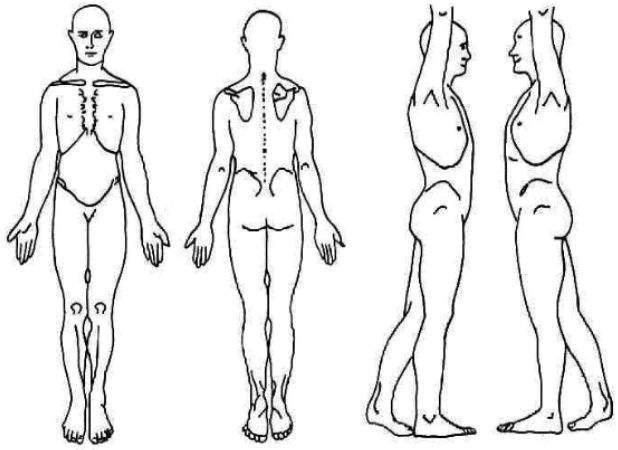
ASCEND
Physical Therapy & Balance Center

Concussion Patient History

Name:			Date:	
Date of Birth:	Age:	Height:	Weight:	Next Doctors Visit:
Occupation:			Have you been a patient here before?	

What brings you to physical therapy?	
Current Problem/Symptoms	When did the problem start?
1.	
2.	
How often do you experience you symptoms? (please circle one) *0-25% intermittently* *26-50% occasionally* *51-75% frequently* *76-100% constantly*	
Are your symptoms changing? (please circle one) *improving* *not changing* *getting worse*	

I currently am not experiencing any symptoms. True ☐ (skip to next page) False ☐ (please fill out below)



What is the nature of your symptoms?											
Circle all that apply Numbness / Tingling Shooting Burning Throbbing Sharp Dull/Achy Weakness Constant Intermittent Other _____ Worse in AM, PM, at night											
What is the intensity level of your SYMPTOMS ?											
At Worst	0	1	2	3	4	5	6	7	8	9	10
	None					Moderate					Severe
Current	0	1	2	3	4	5	6	7	8	9	10
	None					Moderate					Severe
At Best	0	1	2	3	4	5	6	7	8	9	10
	None					Moderate					Severe

Symptoms increases during the following <u>activities</u>	
1)	3)
2)	4)

Symptoms decreases during the following <u>activities</u>	
1)	3)
2)	4)

ASCEND
Physical Therapy & Balance Center

Name:	Date:

Please list your goals in coming to physical therapy.

Please indicate if you have had or have any of the following conditions.					
Condition	Yes	No	Condition	Yes	No
History of Cancer			Pacemaker		
Heart disease			Diabetes I or II		
High/Low blood pressure			Allergies/Asthma		
Angina / Chest pain			Memory Loss		
Shortness of breath			Headaches / Migraines		
Stroke / TIA			Hernia		
Osteoporosis			Nausea or vomiting		
Osteoarthritis			Bowel or bladder problems		
Rheumatoid arthritis			HIV - positive / AIDS/Hepatitis		
Joint replacement			Dementia/Alzheimer's Disease		
Recent excessive weight loss			Pregnant (currently)		
Changes in appetite			Seizures		
Lightheadedness/Dizziness			Fainting		
Frequent loss of balance			Difficulty sleeping		
Falls			Smoking tobacco		
Anxiety / Stress			Vision (glasses / contacts)		
Depression			Hard of hearing / hearing aid		
Fibromyalgia			Lupus		
Obesity			Parkinson's/Huntington's		
TBI/History of Concussions			Alcoholism		

Please list any other medical conditions, surgeries, or health concerns not listed above.	
Condition/Surgery	Date
Which diagnostic tests have you had? (please circle all that apply) *X-Ray MRI CT scan VNG Blood Work PET scan EMG EEG Other:*	

ASCEND
Physical Therapy & Balance Center

Name:	Date:

1. What makes your symptoms better?
2. What makes your symptoms worse?
3. Do you experience light or sound sensitivity? ❑ Yes ❑ No
4. Do you suffer easily from motion sickness? ❑ Yes ❑ No
5. Do you experience hearing difficulty? ❑ Yes ❑ No; pressure, ringing, fullness (please circle)
6. Do you have neck discomfort or injury? ❑ Yes ❑ No
7. Do you have problems with your vision? ❑ Yes ❑ No; double, blurred, trouble reading (please circle)
8. Have you had cognitive testing or Impact testing? ❑ Yes ❑ No
9. Do you have facial or head weakness or numbness? ❑ Yes ❑ No
10. Have you fallen? ❑ Yes ❑ No; If yes, 2 or more falls in the last year? ❑ Yes ❑ No
11. Are you experiencing headaches or migraines? ❑ Yes ❑ No

*****Skip the section below if you do not have dizziness*****

Please describe what you are experiencing (please circle all that apply)

Lightheaded Spinning Dizziness occurs in attacks Pressure in the head
Off balance Sensation that you are turning/spinning Sensation that things are turning around you
Headache Nausea or vomiting Rocking sensation Other:

*If you have **dizziness:**:*

1. When did the dizziness first occur?
2. Is your dizziness constant?
3. Does it come in attacks? ❑ Yes ❑ No
   If yes, how often do the attacks occur? _____
   How long do the attacks last? ❑ seconds ❑ minutes ❑ hours ❑ days ❑ weeks
   Are there symptoms between attacks? ❑ Yes ❑ No
4. Does the dizziness occur only in certain positions? ❑ Yes ❑ No
   If yes, ❑ lying down ❑ sitting up ❑ head movements: up / down / right / left ❑ rolling: right / left
5. Do you have dizziness when exposed to loud noises? ❑ Yes ❑ No
6. Do you have dizziness when exercising or straining? ❑ Yes ❑ No
7. Do you have dizziness when sneezing or laughing? ❑ Yes ❑ No
8. Do you have difficulty in any of these activities? ❑ Yes ❑ No
   ❑ riding/driving a car ❑ malls / crowds / movies

ASCEND
Physical Therapy & Balance Center

Name:	Date:

List all doctors you would like to receive a copy of your physical therapy evaluation.		
MD Name	Address/Phone/Fax	Specialty
Referring MD		
Primary Care MD		
Other MD		

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

ASCEND
Physical Therapy & Balance Center

Medication List

Patient Name: _____ Date: _____

Please list your current medications (including over-the-counter, vitamins, herbal, and dietary supplements).

❑ See attached list

Name	Dosage	Frequency	Administration Route (ex: oral, injection, etc.)	What condition is this for?

Date	Modifications	No Changes	Reviewing Physical Therapist

ASCEND
Physical Therapy & Balance Center

Dizziness Handicap Inventory

Patient Name: _____ Date: _____

Please check "Yes", "Sometimes", or "No" to each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.	Yes	Some-times	No
1. Does looking up increase your problem?			
2. Because of your problem, do you feel frustrated?			
3. Because of your problem, do you restrict your travel for business or recreation?			
4. Does walking down the aisle of a supermarket increase your problem?			
5. Because of your problem, do you have difficulty getting into or out of bed?			
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?			
7. Because of your problem, do you have difficulty reading?			
8. Does performing more ambitious activities like sports or dancing or household chores such as sweeping or putting the dishes away increase the problem?			
9. Because of your problem, are you afraid of leaving your home without someone accompanying you?			
10. Because of your problem, are you embarrassed in front of others?			
11. Do quick movements of your head increase your problem?			
12. Because of your problem, do you avoid heights?			
13. Does turning over in bed increase your problem?			
14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?			
15. Because of your problem, are you afraid people may think you are intoxicated?			
16. Because of your problem, is it difficult for you to go for a walk by yourself?			
17. Does walking down a sidewalk increase your problem?			
18. Because of your problem, is it difficult for you to concentrate?			
19. Because of your problem, is it difficult for you to walk around your house in the dark?			
20. Because of your problem, are you afraid to stay at home?			
21. Because of your problem, do you feel handicapped?			
22. Has your problem placed stress on your relationships with your family or friends?			
23. Because of your problem, are you depressed?			
24. Does your problem interfere with your job or household responsibilities?			
25. Does bending over increase your problem?			

Instructions: Put a check in the box that best describes you:

☐ Negligible symptoms	☐ Performs usual work duties but symptoms interfere with outside activities	☐ Currently on medical leave or had to change jobs because of symptoms
☐ Bothersome symptoms	☐ Symptoms disrupt performance of both usual work duties and outside activities	☐ Unable to work for over one year or established permanent disability with compensation payment

ASCEND
Physical Therapy & Balance Center

Cerebral Concussion

Patient Name: _____ Date: _____

The Post-concussion Symptom Scale is essentially a "state" measure of perceived symptoms associated with concussion. That is, the athlete is asked to report his or her "current" experience of the symptoms. This allows tracking of symptoms over very short intervals, such as consecutive days or every few days. After reading each symptom, please circle the number that best describes the way the athlete has been feeling today. A rating of 0 means they have not experienced this symptom today. A rating of 6 means they have experienced severe problems with this symptom today.

Date of Last known concussion(s):_____

SYMPTOM	None	Mild		Moderate		Severe	
Headaches	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
Sleeping Longer	0	1	2	3	4	5	6
Sleeping Less	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Intolerance to Light	0	1	2	3	4	5	6
Intolerance to Noise	0	1	2	3	4	5	6
Irritation	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
Stronger Emotions	0	1	2	3	4	5	6
Numbness or Tingling	0	1	2	3	4	5	6
Mentally Slower	0	1	2	3	4	5	6
Mentally Blurred	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Visual Problems	0	1	2	3	4	5	6
TOTAL SYMPTOM SCORE:							
GRAND TOTAL OF ALL SYMPTOMS:							

Garden Grove: 12465 Lewis St. #101 Garden Grove, CA 92840 | P: 714-703-8477 | F: 714-703-8157
Buena Park: 5832 Beach Blvd. #114 Buena Park, CA 90621 | P: 714-707-2699 | F: 714-784-2160

ASCEND
Physical Therapy & Balance Center

Neck Disability Index

Patient Name: _____ Date: _____

SECTION I:
Please rate your pain level with activity: *NONE = 0 1 2 3 4 5 6 7 8 9 10 = SEVERE*

SECTION II: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply in the last week.**

Pain Intensity
□ I have no pain at the moment.
□ The pain is very mild at the moment.
□ The pain is moderate at the moment.
□ The pain is fairly severe at the moment.
□ The pain is very severe at the moment.
□ The pain is the worse imaginable at the moment.

Personal Care (washing, dressing, etc)
□ I can look after myself normally without extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self-care.
□ I cannot get dressed, I wash with difficulty and I stay in bed.

Lifting
□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it gives me extra pain.
□ Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
□ Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
□ I can lift only very light weights.
□ I cannot lift or carry anything at all.

Headache
□ I have no headaches at all.
□ I have slight headaches which come infrequently.
□ I have moderate headaches which come infrequently.
□ I have moderate headaches which come frequently.
□ I have severe headaches which come infrequently.
□ I have headaches almost all the time.

Recreation
□ I am able engage in all my recreational activities without pain.
□ I am able to engage in my recreational activities with some pain
□ I am able to engage in most but not all of my usual recreational activities because of my neck pain.
□ I am able to engage in a few of my usual recreational activities with some neck pain.
□ I can hardly do any recreational activities because of neck pain.
□ I can't do any recreational activities at all

Reading
□ I can read as much as I want with no pain in my neck.
□ I can read as much as I want with slight neck pain.
□ I can read as much as I want with moderate neck pain.
□ I can't read as much as I want because of moderate neck pain.
□ I can hardly read at all because of severe neck pain.
□ I cannot read at all because of neck pain.

Work
□ I can do as much as I want to.
□ I can only do my usual work but no more.
□ I can do most of my usual work but no more.
□ I cannot do my usual work.
□ I can hardly do any usual work at all.
□ I cannot do any work at all.

Sleeping
□ Pain does not prevent me from sleeping well.
□ My sleep is slightly disturbed (<1 hr. sleep loss).
□ My sleep is mildly disturbed (1-2 hr. sleep loss).
□ My sleep is moderately disturbed (2-3 hr. sleep loss).
□ My sleep is greatly disturbed (3-4 hr. sleep loss).
□ My sleep is completely disturbed (5-7 hr. sleep loss).

Concentration
□ I can concentrate fully when I want with no difficulty.
□ I can concentrate fully when I want with slight difficulty.
□ I have a fair degree of difficulty concentrating when I want.
□ I have a lot of difficulty concentrating when I want.
□ I have great difficulty concentrating when I want.
□ I cannot concentrate at all.

Driving
□ I can drive my car without neck pain.
□ I can drive my car as long as I want with slight neck pain.
□ I can drive my car as long as I want with moderate neck pain.
□ I can't drive my car as long as I want because of moderate pain.
□ I can hardly drive my car at all because of severe neck pain.
□ I can't drive my car at.