ATLANTIC BALANCE and DIZZINESS CENTRE

PATIENT INFORMATION FORM

Name _____ Birth date (D/M/Y) _____

Street _____ Home Phone _____

City _____ Work Phone _____

Province _____ Cell Phone _____

Postal Code _____ Email _____

Emergency Contact Name _____Phone _____

Employer _____ Occupation _____

Family Physician _____ Referring Physician _____

Date of Injury/Onset _____ Date of Referral _____

Your Personal Health Insurance Company _____

Policy number _____ **ID number** _____

The Atlantic Balance and Dizziness Centre is a private physiotherapy clinic. The cost of the assessment and treatment is not covered by MSI. As the patient, it is your responsibility to verify the amount of any coverage that you may have under your private health insurance. Payment will be expected following each treatment session and receipts will be provided to you. Failure to attend or cancellation with less than 24 hours notice will result in a cancellation fee of $25.00.

Patient Consent

I give permission for information regarding my condition, treatment and progress to be sent to my family and referring physicians, lawyer and/or insurance company responsible for payment of my treatment. I give permission for Atlantic Balance and Dizziness Centre to obtain all diagnostic reports and related information from my physician and/or hospital.

Patient Signature_____ Date _____

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PAST MEDICAL HISTORY

	NO	YES, EXPLAIN
Low/High Blood Pressure		
Cancer		
Epilepsy		
Diabetes		
Stroke/TIA		
Heart Problems		
Pulmonary Conditions (Asthma, Emphysema)		
Circulatory Disorder		
Head Injury (including concussion)		
Neurological Disorder (MS, Parkinson's)		
Dizziness		
Migraines or Headaches		
Low Back or Neck Pain		
Pregnant?		
Metal Implants?		
Pacemaker?		
Bowel or Bladder Problems?		
Medications?		
Other:		

What most influenced your decision to visit this clinic? _____

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Release of Information

I,_____ give Atlantic Balance and Dizziness Centre my consent to release or obtain information from the following individuals with respect to my care by report, letter, phone, fax, email or direct communication:

Physician(s)	_____	_____ Initials
Insurer	_____	_____ Initials
Employer	_____	_____ Initials
Other	_____	_____ Initials

Payment Information

I understand that payment for services received at the clinic is my responsibility. If my insurance company denies my claim or refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding. I understand that the fees per visit for this service are:

Fees: Assessment $ 165.00 Treatment $ 85.00 _____ Initials

Electronic Information

I understand and agree that my health information will be maintained by Atlantic Balance and Dizziness Centre in an electronic form and may be electronically transmitted to those initialled above as required in the course of my treatment.

_____ Initials

Treatment Information

Physiotherapy treatment techniques may include, but are not limited to: manual techniques including spinal manipulation, exercises and patient/family education. It is the policy of Atlantic Balance and Dizziness Centre to fully explain the benefits, side effects and potential complications of each treatment modality prior to its use. If you have any questions or concerns about any aspect of assessment or treatment you are encouraged to ask your therapist and your concerns will be addressed. If at any time you choose not to participate in the program or any portion of it, you must inform your physiotherapist immediately.

I understand and agree with the criteria above and as such agree to participate in an assessment and treatment program at the Atlantic Balance and Dizziness Centre. I understand that for the duration of my treatment, my consent may be withdrawn at any time and that I must inform my physiotherapist.

_____ _____

Signed Date

_____ _____

Witness Date

ATLANTIC BALANCE and DIZZINESS CENTRE

Name:_____ Date:_____

Dizziness Handicap Inventory

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 by writing the corresponding letter in the blanks on the right side of the paper. *Answer each question as it pertains to your dizziness or unsteadiness only.*

Y = Yes (4 pts) **S = Sometimes (2 pts)** **N = No (0 pts)**

1. Does looking up increase your problem? P_____
2. Because of your problem do you feel frustrated? E_____
3. Because of your problem do you restrict your travel for business and/or recreation? F_____
4. Does walking down the aisle of a supermarket increase your problem? P_____
5. Because of your problems do you have difficulty getting into or out of bed? F_____
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing, or parties? F_____
7. Because of your problem do you have difficulty reading? F_____
8. Does performing more ambitious activities like sports, dancing, and household chores such as sweeping or putting dishes away increase your problem? P_____
9. Because of your problems are you afraid to leave your home without having someone accompany you? E_____
10. Because of your problem have you been embarrassed in front of others? E_____
11. Do quick movements of your head increase your problem? P_____
12. Because of your problem do you avoid heights? F_____
13. Does turning over in bed increase your problem? P_____
14. Because of your problem is it difficult to do strenuous housework or yard work? F_____
15. Because of your problem are you afraid people may think you are intoxicated? E_____
16. Because of your problem is it difficult for you to go for a walk by yourself? F_____
17. Does walking down a sidewalk increase your problem? P_____
18. Because of your problem is it difficult for you to concentrate? E_____
19. Because of your problem is it difficult o walk around your house in the dark? F_____
20. Because of your problem are you afraid to stay home alone? E_____
21. Because of your problem do you feel handicapped? E_____
22. Has your problem placed stress on your relationships with your family? E_____
23. Because of your problem are you depressed? E_____
24. Does your problem interfere with your job or household responsibilities? F_____
25. Does bending over increase your problem? P_____

Functional_____(36) Emotional_____(36) Physical_____(28) TOTAL_____(100)